

1. FACE PAGE

Insert Standard Form 424

“Application for Federal Assistance”

2. ABSTRACT

South Dakota (S.D.) has committed to narrowing gaps in services for individuals with co-occurring disorders utilizing SAMHSA's capacity-building goals. The State's plan will concentrate on creating a sustained state-wide infrastructure that will implement quality training procedures on screening and assessment measures as well as address issues of staffing competency, licensure, and credentialing; service coordination and network building; financial planning; information sharing; and barrier reduction. South Dakota is dedicated to five core strategies: 1) establishment of a well-informed and coordinated state-level infrastructure, 2) development of a clear and concrete action plan with regional and local input, 3) development of a plan for the integrated screening process and identification of screening instruments and assessment protocols, 4) development of a quality improvement process to monitor outcomes of the screening process, and 5) development and implementation of a system-wide training curriculum and plan for the 7 Community Mental Health Centers (CMHCs), which are also Core Services Substance Abuse Agencies (CSAs) with a roll-out to all CMHCs and CSAs to follow.

To develop this permanent infrastructure and complete the above named goals, the Governor's Office has committed to facilitating the collaboration of the three service agencies under the Department of Human Services (DHS) and commissioned the Co-Occurring Disorders Steering Committee. This committee, along with a Co-Occurring Program Manager will spearhead the movement towards providing more efficient integrated services across the state. The Co-Occurring Steering Committee will be composed of personnel from the State's Division of Alcohol and Drug Abuse (DADA) and Division of Mental Health (DMH), Community Mental Health Centers (CMHCs) Core Services Substance Abuse Agencies (CSAs), other State divisions (e.g., Department of Corrections, Social Services), and stakeholders from the community (e.g., consumer advocacy groups, Native American organizations). Committees will be charged with oversight of the project in their areas and finding solutions to multilevel barriers to service integration.

With stakeholder input, independent evaluators will help develop the necessary training curriculum, collect data regarding training outcomes and clinical performance, then help to modify training and/or implementation as needed. The project will be conducted at the seven CMHCs/ CSAs and the HSC (State Hospital). Data collection and analysis will be built into all phases of the project. The project will enable success by providing opportunities to further identify barriers to integrated services, creative solutions, and a solid knowledge base for expanding into other regions or agencies in the State. As the system crystallizes across the State, South Dakota will be able to build on its success through future development of programs that provide comprehensive, integrated services to individuals with co-occurring disorders.

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4. BUDGET INFORMATION

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**“Budget Information – Non-Construction Program”
page 1**

Form 424A page 2

1. PROJECT NARRATIVE AND SUPPORTING DOCUMENTATION

A. DOCUMENTATION OF NEED/PROPOSED APPROACH

A.1 UNDERSTANDING THE PROBLEM

The impact of co-occurring disorders on health, productivity and life spans of South Dakotans has historically been underestimated. While individuals with a single diagnosis are typically receiving adequate care, the simultaneous presence of both substance abuse and a mental disorder in an individual has a significant adverse impact on treatment efficacy and prognosis. Individuals who have both issues are more likely to relapse, use emergency services and are more difficult to treat. This is especially true when only one diagnosis is being addressed in treatment or the treatment philosophies for each diagnosis conflict with each other. Aided by the development of evidence-based treatments for co-occurring disorders, South Dakota (S.D.) is moving to establish integrated systems to more effectively serve this population.

Definition

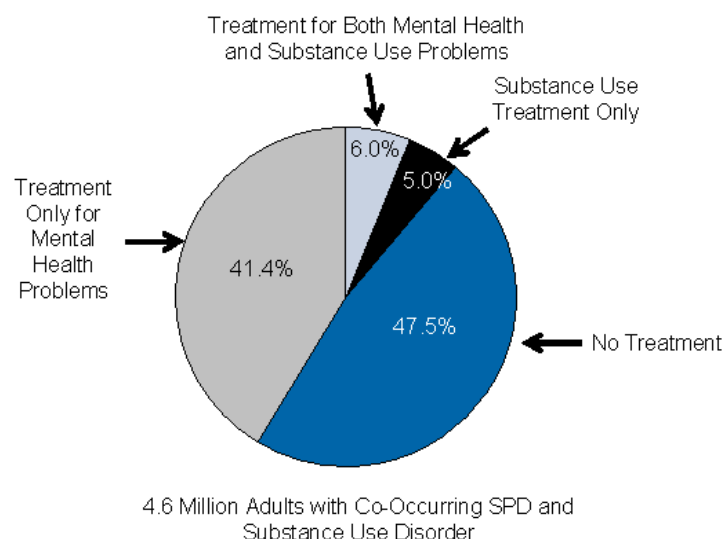
The Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders (U.S.D.H.H.S: SAMHSA, 2002) adopts the term “co-occurring disorders” to identify persons with both substance abuse and mental disorders, using a definition developed by an expert panel. The definition is, in part, “...individuals who have at least one mental disorder as well as an alcohol or drug use disorder” (p. 2) based on DSM-IV criteria. Either disorder may lead to or exacerbate the other, but each can be diagnosed independently. Symptom severity for either disorder can range from mild to severe concurrently or vary over time, with symptoms of one being of greater or less intensity than symptoms of the other. A recent review of the literature (Mueser et al., 1998) indicates four general models for understanding how co-occurring disorders develop (paraphrased here): 1) environmental or experiential risk factors (e.g., low socioeconomic status, relationship loss), 2) serious mental illness (SMI) as precursor to substance abuse, 3) substance abuse that leads to SMI, and 4) either SMI or substance abuse increases vulnerability to the other disorder. In any of these cases,

A.1.1 The Scope of the Problem

According to the 2004 National Survey on Drug Use and Health, adults with co-occurring disorders comprised 21.3 percent (4.6 million) of the population. Only 41.4 percent (2.2 million) received treatment for mental health problems, and 5.0 percent (503,000 adults) received specialty substance use treatment. About half (47.5 percent) did not receive treatment for either problem. Only 6.0 percent (274,000 adults) received both treatment for mental health problems and specialty substance use treatment.

Those individuals with more than one mental health disorder will more likely become substance abusers (Costello et al., 2000). Substance abuse can co-occur with less debilitating mental disorders (e.g., anxiety) or serious mental illness (SMI; e.g., schizophrenia). However, research indicates that individuals with SMI are far more likely to have a co-occurring substance abuse disorder (Harris & Edlund, 2005). Co-occurring disorders are a major concern because they are, in effect, a draining and demoralizing “double burden.” It is not surprising that the rates of suicide are much higher for people with co-occurring disorders than those of the general population (Jaffee & Ciraulo, 1986; in RachBeisel & McDuff, 1995).

Figure 1: Past Year Treatment among Adults Aged 18 or Older with Both Serious Psychological Distress and a Substance Use Disorder: 2004¹



Note: Due to rounding, these percentages do not add to 100 percent.

A.1.2 Treatment Barriers

The long-standing division between substance abuse and mental health treatment affects individuals with co-occurring disorders seeking services and service providers in multiple ways. Regardless of when or how one develops a co-occurring disorder, treatment options have been historically poor. Five general barriers that subsume a number of federal, State, and local issues regard: 1) policy; 2) funding; 3) program; 4) clinical; and 5) consumer and family. In essence, services for mental and substance abuse disorders have typically been separate due to policy, separate funding streams, credentialing laws, and training. On the consumer side, issues of stigma and a lack of public educational material make understanding problems and pursuing available help difficult. Also, denial or minimization of problems impedes seeking help. Finally, persons with co-occurring disorders require significant social and clinical support. Family members may not be in a position to recognize the severity of symptoms or offer help. If one has limited social support or a clinician that, for whatever reasons, cannot provide stable and consistent treatment, overcoming the problems is very difficult.

A.1.3 Integrated, Comprehensive and Evidence-Based Treatments

State-of-the-art, effective services for co-occurring disorders are integrated, comprehensive, and evidence-based. *Integrated* services address both substance abuse and mental disorders in facilities with the infrastructure to provide such services, and the system of care supports those facilities via appropriate funding, credentialing/licensing issues, and assessment of needs and outcomes. Integrating substance abuse and mental health treatment requires conceptual clarity that leads to practical action. A significant step in this regard has been taken by the NASMHPD/NASADAD Joint Task Force on Co-Occurring Disorders with their description of the “Four Quadrant Framework” (2005). This framework helps appropriately identify the nature of an

¹2004 National Survey on Drug Use & Health: Results; Department of Health and Human Services

individual's co-occurring disorder and, thereby, guides that person to the most effective treatment.

Comprehensive services refer to a broad range of treatment options beyond substance abuse or mental health. Model programs offer help with housing, medical care, employment, transportation, limited financial help, and typically involve community outreach with community-based (i.e., "in-vivo") services (e.g., Assertive Community Treatment or ACT).

Evidence-based practices (EBPs) generally refer to treatments that have repeatedly demonstrated through rigorous scientific research effectiveness in treating a given disorder. Evidence-based practices imply self-knowledge, self-determination, choice, individualization, and recovery.

The complexity of co-occurring disorders has made it difficult to define EBPs for this population. However, SAMHSA has published *The Co-Occurring Disorders: Integrated Dual Disorders Treatment, Implementation Resource Kit* (2003 Draft version) that provides guidance on how to implement evidence-based practices in treatment of co-occurring disorders at all levels of treatment.

A.1.4 Co-Occurring State Incentive Grant (COSIG)

The Healthy People 2010 initiative notes that in the past century we have made great strides in improving the health of the American people. However it also notes that there are still many challenges ahead. Most salient here are focus areas 18 (Mental Health) and 26 (Substance Abuse). The COSIG grant was developed partly in response to this initiative as well as in response to the recent Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse and Mental Disorders (2002). The grant seeks to provide the means and guidance for States to become leaders in change to better the lives of those with co-occurring disorders. The current grant opportunity to facilitate integration is a major initiative toward overcoming significant barriers for individuals with co-occurring disorders in seeking and receiving treatment.

A.2. THE SOUTH DAKOTA STATE SYSTEM

A.2.1 Prevalence of Co-Occurring Disorders in South Dakota

There has been a growing understanding, paralleling national trends, that individuals with co-occurring issues in South Dakota are more prevalent than previously believed and/or that the data indicate. Quantifying a definitive number of persons with co-occurring disorders has been problematic primarily because of separate data collection systems structured to focus on either mental health clients or substance abuse clients.

A preliminary analysis of the number of individuals receiving treatment for co-occurring disorders in S.D. was conducted based on 2000 U.S. Census data (see Table 1 below). The analysis was based on individuals in substance abuse (SA) and mental health (MH) database files that had either 1) both a substance abuse and mental health diagnosis or 2) were served by both Divisions. However, the results of the analysis are likely an under-representation of the prevalence of co-occurring disorders in S.D. for several reasons: a) it cannot be assumed that all persons treated in either system who have co-occurring disorders were diagnosed with both disorders, b) the databases do not include all persons served in S.D., and c) the databases include only those who have received services and, therefore, do not account for people in the state with co-occurring disorders who have not received services.

Overall, the number of individuals in the substance abuse database identified as having a co-occurring disorder represents 6.5% of the people in that database, while the number in the

mental health database represents 10.3% of the people in that database. Taken together, 8.2% of the people receiving services are identified as having a co-occurring disorder. The 12-17 year-old age group has the largest number of individuals identified with co-occurring disorders, with those in the 35-44 age group having the second highest cumulative total. Other data presented in this section will provide a clearer picture of the individuals receiving either substance abuse or mental health services.

Table 1: Estimate of Individuals with Co-Occurring Disorders Receiving Services										
Division	Age Group									Total
	6-11	12-17	18-20	21-24	25-34	35-44	45-54	55-64	65+	
SA	5	471	55	63	113	155	76	13	7	958
MH	3	300	142	77	166	255	173	53	20	1,189

In terms of substance abuse services statewide, services were largely delivered to males (70%) and those between the ages of 18 and 44. The source of the greatest percent of referrals was some component of the legal system (i.e., court, Department of Corrections). The primary substance of abuse was alcohol (64%), with Cannabis as the most common secondary substance of abuse (25%). (For other significant findings regarding substance abuse, please go to <http://www.state.sd.us/dhs/ADA/clientsum00.pdf>.)

Additionally, the DADA reports that “more than one-fourth of South Dakota adults in the target population who needed substance abuse treatment perceived their mental health as being fair or poor.” Sizable percentages of adults needing substance abuse treatment also had medical problems in the past year.

Table 2: Estimates of Need for Mental Health Services in Participating Communities											
Facility	Age	≤300% Pov-erty	Gender		Race/Ethnicity						Lang- uage Spoken
			M	F	C	AI	B	H	A	O	
HSC Yankton	0-17	12,155	6239	5,916	9,382	2315	101	287	70	0	English
	18+	20,635	7266	13,369	18,363	1721	61	312	176	2	English
CAC Pierre	0-17	592	306	286	392	189	1	8	2	0	English
	18+	868	316	552	718	137	1	9	3	0	English
CCS Huron	0-17	655	333	322	607	33	4	9	2	0	English
	18+	1,219	448	771	1,173	27	2	9	7	1	English
ECM Brook-ings	0-17	347	174	173	330	7	1	6	3	0	English
	18+	835	321	514	815	6	1	7	5	1	English

HSA Water- town	0- 17	1,070	536	535	932	121	2	13	2	0	English
	18 +	1,823	695	1,128	1,706	96	1	14	6	0	English
LCB Yankton	0- 17	1,253	634	619	1,077	139	7	21	8	1	English
	18 +	2,245	814	1431	2,087	111	5	24	18	0	English
TRM Lemmon	0- 17	459	228	231	100	352	0	7	0	0	English
	18 +	516	189	327	240	271	0	4	1	0	English

Table 2 indicates the population demographics related to estimates of need for mental health services in these areas for those who fall below the 300% poverty guideline and are, therefore, whom the DADA and DMH primarily direct their services. The data for the Core Service Agencies (CSA), the Community Mental Health Centers (CMHCs) and the Human Services Center (HSC; State Hospital) are presented here because these facilities serve a large area of South Dakota and give reasonable estimates of the population demographics and clinical characteristics of those in various regions of the state.

A.2.2 South Dakota's Service Delivery System: South Dakota's Division of Mental Health (DMH) and the Division of Alcohol and Drug Abuse (DADA) are part of the Department of Human Services, which also includes Developmental Disabilities, Rehabilitation Services, Service to the Blind and Visually Impaired, the South Dakota Developmental Center-Redfield, and the Human Services Center (HSC), which is the State Hospital.

Division of Mental Health (DMH)

The DMH provides a range of services through purchase of service agreements with eleven private, non-profit community mental health centers (CMHCs). The principle responsibilities of the Division of Mental Health are to establish policy, to develop and administer the implementation of the Community Mental Health Services block grant, to determine and establish reasonable standards and requirements for the locally operated community mental health centers, and to enter into purchase of services agreements for the purpose of assisting in the operation and programs of the local mental health centers.

The DMH serves adults with Severe and Persistent Mental Illness (SPMI) and children with Serious Emotional Disturbance (SED). Services provided through purchase of service agreements include: case management, individual therapy, crisis assessment and intervention, liaison services, symptom assessment and evaluation, family education/support/therapy, and a system of communication and planning. Eleven CMHCs are the focal point for comprehensive services to consumers and must meet administrative rules disseminated by DMH. Each is designated catchment areas to insure services are provided to all of the state's 66 counties. These centers have demonstrated a commitment to providing quality services despite overcoming a number of environmental barriers, including those created by the State's cultural and socioeconomic composition.

The DMH also has the responsibility for the delivery of mental health services within the State's adult and juvenile correctional facilities. In addition, the DMH is responsible for a state-

operated program of assertive community treatment, known as IMPACT-Yankton (Individualized and Mobile Program of Assertive Community Treatment). IMPACT-Yankton is a state and federally funded program that provides intensive services to individuals with excessive histories of hospitalizations who need very intense services to remain in the community.

In carrying out these responsibilities, the Division of Mental Health staff consists of a full-time director; a program manager for community mental health services who oversees two program specialists, an IMPACT program manager, eleven IMPACT mental health professionals, and one IMPACT secretary; a program manager for correctional mental health services who oversees twelve mental health professionals and one secretary in the adult and juvenile correctional facilities; three additional program specialists, and a secretary. DMH currently has eight FTE's that work closely with the eleven CMHCs throughout South Dakota. The DMH also has fourteen FTE's in the correction system providing mental health services to inmates as needed. In addition to these staff, the DMH also provides psychiatric care for inmates through contractual arrangements with psychiatrists.

Division of Alcohol and Drug Abuse (DADA)

The DADA also serves adults and adolescents, particularly those within the 185% of poverty guideline, pregnant women or women with dependent children, intravenous drug users, individuals medically impaired because of chemical dependency, and those under the care of the Department of Corrections (DOC). DADA contracts with numerous accredited community agencies or programs (58 in all) to provide prevention, as well as inpatient and outpatient treatment services. In fiscal year 2005, DADA served a total of 16,394 clients with services ranging from crisis intervention to structured treatment programs. DADA also provides prevention, outreach, and interaction with the state hospital and criminal justice system.

In the last three years the State of South Dakota has seen a significant rise in the number of people referred to residential treatment programming with a Methamphetamine Diagnosis. The table below summarizes this increase.

Table 3

	Methamphetamine Diagnosis	Applicants	% of all applicants for residential with a methamphetamine diagnosis
FY02	209	2,042	10.2%
FY03	467	2,072	22.5%
FY04	511	2,001	25.5%
FY05	550*	2,076	26.5%

*** 448 Adults, 48 Adolescents, 54 Pregnant Women**

In addition to being addicted to methamphetamines, these individuals also experience a number of health related problems and exhibit significant mental health issues that need to be addressed during their treatment stay.

A significant percent of individuals who receive substance abuse services are referred through some aspect of the legal system, which highlights the well-documented relationship between substance abuse and legal problems. However, less than half of those entering the system are referred to direct substance abuse services.

Joint Efforts (DMH & DADA)

At present, seven of the eleven CMHC facilities are designated as “Core Service Agencies” (CSAs) that provide both mental health and substance abuse services. These are Capital Area Services (Pierre), Community Counseling Services (Huron), Dakota Counseling Institute (Mitchell), East Central MH/CD (Brookings), Human Service Agency (Watertown), Lewis and Clark Behavioral Health Services (Yankton), and Three Rivers MH/CD (Lemmon). Each facility has an administrative structure that oversees the delivery of mental health and substance abuse services, which range from crisis intervention to outpatient therapy or psychiatric treatment to ACT programs.

Other points of integration are the Human Services Center (HSC), a licensed hospital, providing inpatient adolescent and adult psychiatric and chemical dependence services, including assessment, therapy, medication, and community placement. HSC admits approximately 2100 consumers annually with either mental illness or chemical dependency diagnoses, but many have both diagnoses and compose a large percent of those who return to the hospital within 30 days of discharge. Currently HSC attempts to screen patients showing signs of both disorders, but due to capacity of treatment areas and differences in criteria for admission or committal, many patients that could benefit from integrated services are not able to receive them. The Center has made significant strides in this area recently by adding a certified chemical dependency counselor in the admissions office.

The DADA has also established a specialized program for substance abusing pregnant women and women with dependency issues, operated by Behavior Management Services, which is the CMHC with a ten county catchment area in western South Dakota. This 15 bed program provides a full array of alcohol and drug and mental health services to this population within their treatment program.

Additionally, the DMH and DADA offer mental health and substance abuse services, respectively, to adults and juveniles in the DOC. Mental health services include group and individual therapy, intake screenings, assessment, family counseling, crisis response, and discharge planning. Substance abuse services include screening, assessment, prevention education classes, pre-treatment classes, intensive outpatient treatment programming, and continuing care, to name just a few. (For more information all the services offered by both the DMH and DADA in the DOC, please go to <http://www.state.sd.us/dhs/dmh/docmh.htm> and <http://www.state.sd.us/dhs/ada/scorrins.htm>).

The DADA, through technical assistance from SAMSHA, developed a contract with Duane Mackey, an Ed.D. from the University of South Dakota, to develop a cultural competency assessment tool to determine if agencies are providing culturally competent services. He also developed 24 training modules that focus on training people to be more culturally competent in deal with their Native American clients. The modules are completed and he has done at least three trainings with provider agencies in the State.

A.2.3 Action Taken/Current Planning Efforts

Support from upper level policy makers in South Dakota is critical to provide political backing for this co-occurring initiative. To this end, the Department has the ongoing support of the Governor’s Office through a liaison to the Department. A representative from the Governor’s Office was a member of the original Policy Academy Team as well.

Despite having a number of facilities that provide both substance abuse and mental health services, the structural components of the system generally, and in those facilities, is such that the services are not fully integrated. Regarding treatment programs that screen, assess, and

provide integrated treatment for individuals with co-occurring disorders, as well as the percentage of consumers who experience reductions in impairment, generally, the facilities that provide both substance and mental health services (although not necessarily in an integrated manner) are the seven CMHCs/CSAs, the HSC, Department of Corrections, and Serenity Hills, which is the only facility created jointly by the DADA and DMH with blended funding. Otherwise, funding, procedures, billing codes, and regulations are different. Planning efforts and initiatives to better serve the co-occurring population are detailed below.

Infrastructure and Strategy

In 2004, DMH and DADA contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program conduct an evaluation of 1) current treatment programs in South Dakota for persons with co-occurring mental health and substance abuse disorders and 2) agency readiness (i.e., community mental health and alcohol and drug providers) to develop programs that achieve high fidelity to best practices in the field. A web-based survey was developed in accordance with the components of an evidence-based treatment program described in the SAMHSA toolkit for co-occurring disorders. The evaluation of agency readiness to develop model programs was based on work by the Tri Ethnic Center for Prevention Research at Colorado State University on “Community Readiness” for change. (More information on this report can be obtained from the Division of Mental Health.) This project provided essential information as S.D. moves toward the integration of mental health and substance abuse services to improve treatment outcomes for persons with co-occurring disorders.

Second, the DMH and DADA jointly applied for a Child and Adolescent Mental Health and Substance Abuse State Incentive Grant. If funded, this would provide for infrastructure development to support a system of care for children and adolescents with mental health and/or substance abuse and their families to access appropriate services in their communities and avoid out-of-home placement. Building systems of care that include key elements such as service coordination, family involvement, and culturally competent services are critical to the well-being of children with mental health and/or substance abuse disorders in South Dakota.

Third, S.D. had the opportunity to take part in a SAMHSA-sponsored Policy Academy on Co-Occurring Disorders in 2004. This Policy Academy allowed the State to bring together a group of individuals that can effect change in provision of services to individuals with Co-Occurring substance abuse and mental health diagnoses across the state. An Action Plan was developed to address issues around delivery of services to individuals with Co-Occurring Disorders.

Since the Policy Academy in 2004, South Dakota has been working with Kenneth Minkoff, MD, and Christie Cline, MD, from ZiaLogic, Inc, a professional services corporation specializing in guiding State and regional clients through the complex process of developing and implementing major systems change for individuals with co-occurring disorders. Efforts have been centered on consensus building across service systems and community members (e.g., consumers, providers, government representatives) to move toward more integrated policies, services, and financing serving people with co-occurring disorders.

- Changed some processes at the HSC; the only state operated substance abuse program for both adolescents and adults
- A chemical dependency counselor is now in the admissions office of the HSC so consumers are getting screened for substance abuse as they enter
- Alcohol and drug staff are working with mental health staff in correctional facilities

- Integrated COD models are starting to appear in correctional facilities (all without any additional dollars)
- Have been running a COD halfway house for about six years
- Looking at rewriting administrative rules and adding a section on COD competency
- South Dakota is working with some of its larger jurisdictions on issues of COD interventions; trying to identify rules and guidelines that will allow detoxification centers to act as a center for assessment of mental health problems as well

Fourth, the S.D. Co-Occurring Disorder Steering Committee was created last year to begin the process of increasing stakeholder buy-in for a more integrated mental health and substance abuse system. The idea behind this initial effort was to create an environment for change which included modifying the paradigm of previously separate mental health and substance abuse systems, building political will through education and partnership, and communicating the importance of this project to stakeholders throughout S.D. The Steering Committee is composed of individuals from multiple state and community agencies including the DMH, DADA, Developmental Disabilities, Rehabilitation, Native American and Indian Health Services, Corrections, Judicial System, consumers, and other providers. The Steering Committee meets quarterly to continue developing system transformation strategies for the State.

Finally, another important point is that the Division of Developmental Disabilities has expressed interest in participating in this project to further widen the “no wrong door” philosophy. As a part of the Department of Human Services, they will play a key role in the continued quality improvement efforts that result from addressing co-occurring disorders.

Information Sharing

Until recently, the DADA and DMH collected and stored data separately. However, both the DADA and DMH received Federal Infrastructure Grant awards, which were used to create a Management Information System (MIS) that integrates DADA and DMH data. The DMH and the DADA created a web-based MIS called STARS (State Treatment and Reporting System), which was implemented statewide in June 2005. STARS collects demographic, diagnosis and service utilization data for all individuals receiving publicly funded mental health and/or substance abuse services.

Collection of this data now allows both Divisions increased capability for reporting to SAMHSA on NOMS. Along with this reporting, STARS now allows DMH and DADA to create reports containing data relative not only to individuals with co-occurring diagnoses, but also to individuals actually utilizing both mental health and alcohol/drug services. With the increased data, both Divisions can better determine the service needs of individuals receiving these services. Reports can now be generated that will provide the needed additional information to develop policies/procedures relative to integrated treatment for individuals with co-occurring disorders.

Standardized Screening and Assessment

Standardized screening is currently being implemented at one site in South Dakota (i.e., HSC). Implementation of this process began in May, 2005. Since that time, they have identified 306 potential screenings and completed a total of 240 (78%). The HSC uses the following assessment tools: the Chemical Dependency Screening, the Michigan Alcohol Screening Tool, The Drug Abuse Screening Tool, and the DSM criteria for Pathological Gambling code 312.31.

Training and Education

Currently, two separate groups of professionals with different credentialing requirements are charged with delivering treatment to individuals with co-occurring disorders. At this point, there

is no coordinated educational or training effort across the two disciplines. However, in the screening project mentioned above, the HSC provided training on the screening process to social workers, unit staff, and physicians in both a one-on-one and group format.

A.2.4 Limitations

Despite having points of integration of substance abuse and mental health services, South Dakota is no exception to the description of significant gaps in systems of care, science, and services contained in the *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders* (D.H.H.S: SAMHSA, 2002) and *Mental Health: A Report of the Surgeon General's* (D.H.H.S., 1999). Although the State continuously seeks to implement integrated mental health and substance abuse treatments into community and hospital practices, this has been a slow process.

South Dakota is a largely rural state, with approximately 10 persons per square mile, compared to about 80 per square mile across the United States. It is also one of the least urbanized states, with most of the population living in the southeastern portion of the state, near the largest city, Sioux Falls. In 2000, only 52 percent of the state's residents lived in urban areas. These geographic realities create unique barriers that compound those already described.

In addition, South Dakota has a large Native American population, a significant percentage of which are receiving treatment for substance abuse or mental disorders. For instance, of 17,190 persons served through DADA in 2003, 4,244 (25%) were Native American. This information further highlights the need to include Native Americans. As will be described in a subsequent section, cultural competence and inclusion of Native Americans will be a major component of all levels of the grant project.

Other barriers to integrated services in South Dakota include: 1) non-integrated funding sources and streams between substance abuse and mental health, 2) budget constraints, 3) separate credentialing/licensure procedures, training and continuing education programs, as well as professional guild associations, 4) staffing limitations, 5) multidimensional stigma.

A.3 THE SOUTH DAKOTA CO-OCCURRING SYSTEM TRANSFORMATION INITIATIVE

The entire sequence of activities proposed in South Dakota's plan to achieve the capacity-building goals has the purpose of narrowing gaps in services and, therefore, providing more effective treatment. Both DADA and DMH are committed to a shared vision of integrated services, which require collaborations with other state and local agencies/facilities. Successful treatment of individuals with co-occurring disorders is dependent upon a developed, sustained infrastructure, including ongoing training, supervision, information technology and interagency coordination (Corrigan et al., 2001). South Dakota has committed to concentrating the efforts in this grant period to **infrastructure development and implementation of integrated assessment and screening with the CMHCs, CSAs and the HSC**. As a result of some of the ongoing planning efforts mentioned in the previous section, South Dakota already has many agencies interested in this program and therefore, will not be using pilots during this grant period.

South Dakota is dedicated to five core strategies: 1) establishment of a well-informed and coordinated state-level infrastructure, 2) development of a clear and concrete action plan with regional and local input, 3) development of a plan for the integrated screening process and identification of screening instruments and assessment protocols, 4) development of a quality improvement process to monitor outcomes of the screening process, and 5) development and

implementation of a system-wide training curriculum and plan for the 7 CMHC/CSAs, with a role out to all CMHCs and CSAs to follow. The first two strategies are system level goals that set the foundation to address capacity building goals within the five infrastructure areas.

These strategies serve to provide a strong infrastructure to support the activities needed to implement SAMHSA's capacity-building goals of appropriate **training** in uniform, valid, and reliable **screening** and **assessment** procedures for providers in multiple settings to competently **treat** individuals with co-occurring disorders. Implementing these goals is necessary to ensure that referral to appropriate treatment pathways occurs and the likelihood of positive outcomes is greatly improved. The strategies listed below work toward creating an organized foundation to address issues of **infrastructure development, staffing competency, licensure, and credentialing; service coordination and network building; financial planning; and information sharing**. South Dakota is committed to coordinating with SAMHSA's Co-Occurring Center for Excellence (COCE) during the grant period.

The partnership between the DMH and the DADA, enhanced by support from the Governor's Office, will allow South Dakota to build on previous efforts to integrate services and improve treatment for individuals with co-occurring disorders. The leadership of this effort will work to facilitate a culture of change in South Dakota regarding the treatment of people with substance abuse and mental health disorders. The leadership will also identify key individuals to serve as "change agents" in their agencies and communities to build consensus and maintain momentum in this integration effort.

Strategy 1: Develop a well-informed and integrated planning and implementation structure between the DHS agencies (DMH, DADA, and HSC), a DHS Co-Occurring Program Manager, the Co-Occurring Steering Committee, and external consultants.

As with similar systems in other states, there is a long history of separate policies, procedures, training, and service modalities which divide providers and programs that otherwise share common goals. Thus, it is essential that the first strategy be dedicated to establishing a strong infrastructure that will provide a permanent support base for South Dakota's co-occurring populations. This process has two interactive levels of focus: organizational and clinical. The organizational component will involve stakeholders across disciplines identifying barriers to service integration at legislative, funding, and administrative levels, then identifying solutions.

In order to encourage lasting changes in system infrastructure and treatment delivery models, South Dakota will utilize the CCISC implementation toolkit including the COFIT™ system evaluation tool to measure targets for change. Infrastructure development activities will insure that programs are prepared for an integrated screening and assessment process, that they are adequately trained to deliver screening, assessment, and referral services, and that there are quality improvement procedures embedded in the process to monitor co-occurring grant outcomes.

Hire a DHS Co-Occurring Program Manager. This position will be charged with bringing together the three DHS divisions, coordinating the Steering Committee, the external consultants, CMHCs, and CSAs to develop the action plan and to act as a liaison to state and community stakeholders. Other responsibilities include:

- Articulate vision and expectations to staff and consultants.
- Provide general direction and oversight.
- Encourage consensus building via regional and state meetings or focus groups.
- Ensure the commitment of stakeholders in the program including the involvement of the Advisory Councils and interested stakeholders.

- Identify potential policy changes to increase sustainability.
- Coordinate the efforts of the consultants and evaluators.
- Oversee the completion of quarterly and annual reports.

Co-Occurring Disorders Steering Committee. Conventional boundaries between single-focus agencies impede the clinical progress of persons with co-occurring disorders. Network building will help South Dakota develop more effective linkages across systems of care. The Co-Occurring Steering Committee, under the direction of the Program Manager, will serve as a resource and oversight body to develop networks at the state, regional and local levels. At the beginning of the grant period, it is likely that the Steering Committee will need to meet on a frequent basis (e.g., once per month). This team will direct strategic planning, monitor implementation, and organize quality improvement methodology for meeting objectives and effecting system integration changes. The committee will also have specific responsibilities designed to ensure continuous coordination which yields the most efficient use of agency resources and the elimination of service redundancies.

The Steering Committee will also guide the development of training curricula and will review state licensure, credentialing policies to identify barriers to implementation of training. The Steering Committee will also examine current treatment funding and reimbursement structures for individuals with co-occurring disorders.

An important function of the Steering Committee will be to ensure the inclusiveness of Native populations at every level of this project. If there is inadequate representation in planning efforts, the Steering Committee will identify ways to increase the visibility and voice of Native populations in South Dakota in this project.

The Steering Committee will ultimately research and develop a plan (including realistic guidelines) with the assistance of consumers, Native Americans, and other individuals with specific expertise for each of five identified systemic barriers within the five critical infrastructure development areas:

- *Standardized Screening and Assessment*
- *Complementary Licensure and Credentialing Requirements*
- *Service Coordination and Network Building*
- *Financial Planning*
- *Information Sharing*

Establish and Extend the Communications System. While there is growing communication among the three divisions of the DHS regarding treatment of co-occurring disorders, they have separate administrative structures, constituencies, mandates, and target groups. The goal of information sharing through utilization of the recently established management information system (STARS) is to increase communication between providers so that treatment is more suited to the person's personal needs and characteristics by linking services and information across different systems and levels of care.

An electronic media forum will be developed for 1) consistent and ongoing forum for communication between departments and divisions, 2) a forum for technical assistance on all aspects of training and software implementation, 3) training and continuing education. Specific activities related to these areas are listed:

- **Leadership Conference Calls** that will occur on a bi-monthly basis.
- **Co-Occurring Listserv** that will allow partners to efficiently communicate with one another and will heighten technical assistance. Membership will be limited to project

sites and key stakeholders. WICHE staff will monitor the listserv, post notices for upcoming releases of best practices, summaries of new developments, etc. Subscribers will be encouraged to use the listserv to share information, and also to seek advice from colleagues in the other locations.

- **Webcasts & Grand Rounds** built into the training plan. During real-time audio visual presentations over the web, attendees can communicate with other attendees and the speaker via the “chat box.” Webcasts will be archived and available from the website for later viewing. Grand rounds can be filmed at a central location and archived to the web.
- **Document Exchange** that will be available through a password-protected Web site for the exchange and collaboration of documents among program sites.
- An **information-sharing system** will be created so there is ongoing communication about the changes, including successes, barriers, and other important issues regarding implementation.

External Consulting Team. The team will involve staff from the ZiaLogic Consultation Team and consultants for other areas such as communication networking, evaluation (WICHE), and regulatory redesign.

Diversity, Cultural Competence, and Consumer Involvement. South Dakota is committed to providing services to individuals regardless of their background or if they have disabilities. The state intends to address these issues throughout the process. First, stakeholders representing minority cultures (e.g., Indian Health Services) will be invited to participate in the statewide Search Conference at the outset of the grant period. Similarly, members of these organizations will be invited to serve on regional subcommittees, sharing oversight responsibilities. Clinicians from facilities that serve consumers with diverse backgrounds and consumers will be asked to provide feedback via regional focus groups regarding the effectiveness and competence of services. General issues regarding Native American populations and rural health will be a core component of implementation training. On-site, specific cultural competence and diversity issues will be addressed at each of the sites. Additionally, as the project expands, training for clinicians will involve dissemination of cultural sensitivity related to the screening and assessment protocols.

In this regard, the selection of the screening and assessment instruments to be implemented will need to demonstrate sound psychometric properties and cultural sensitivity. Inherent in this selection process will be an evaluation of the applicability of a given instrument to a wide range of people, including individuals with learning, literacy, visual, auditory, or language barriers. Thus, the instruments should have alternative administration procedures for special circumstances. In the event that all the instruments reviewed lack the scope of application desired, stakeholders will utilize the best instruments and determine the appropriateness of altering them to widen their applicability.

South Dakota will collaborate with the WICHE Mental Health Program, which has an extensive background in cultural competence. For instance, in partnership with SAMHSA, WICHE developed standards in mental health across different ethnicities/races². WICHE coordinated the CMHS activities of four national racial/ethnic panels with 72 members from America’s underserved-underrepresented racial/ethnic groups (African American, Asian

² Guidelines can be found at http://www.wiche.edu/MentalHealth/Cultural_Comp/ccs19.htm.

American/Pacific Islander, Hispanic/Latino, and Native American). These groups produced the SAMHSA/CMHS *National Standards for Cultural Competence*. WICHE has close association with public mental health entities, universities, colleges, tribal colleges, national and international educational and mental health organizations that will provide access to a large resource base for language and cultural expertise.

As described earlier, various groups or organizations will be invited to participate in the state-wide stakeholder conference, subcommittees, and focus groups. For example Indian Health Services, other state and national cultural competency experts, and consumers will address implementation issues. Training regarding consumer sensitivity and cultural competence will be provided through consultation with experts, outreach programs, conference time devoted to these topics, and continuing education courses/programs via electronic media. Consumers and family members sitting on the regional subcommittees will review these plans for appropriateness and comprehensiveness. NAMI South Dakota will provide further technical assistance for latest developments in medicines, legislation, treatment, family psychoeducation and other issues affecting consumers and families.

Strategy 2: Utilize the state-level infrastructure to build lasting consensus for infrastructure change at the regional and local levels. Finalize a clear and articulated action plan to permanently align service provision. The Program Manager and the Steering Committee, with the direction of the consulting team, will be responsible for establishing regional and local Co-Occurring Coordinating Groups and the finalization of an action plan that integrates stakeholder input and necessary cultural components.

Conduct a State-Wide Stakeholder Conference. The Program Manager and the Steering Committee will convene a conference that brings diverse stakeholders together to discuss service integration, followed by regional focus groups and the establishment of state and local subcommittees charged with further developing the action plans started at the policy academy. This conference will build upon the previous planning meeting, which occurred on March 28 and 29, 2006, and will be a forum to review progress as a result of South Dakota's participating in the Policy Academy and its work with Drs. Minkoff and Cline. Part of this process will include assessments of current barriers to integration and facility/provider readiness for change as discussed throughout the strategies. The ideas and data generated from these processes will serve as the basis for the action plan that charts out the steps that need to be taken at multiple levels to ensure success.

The statewide conference will be one of the major steps in bringing together stakeholders from across the state to begin the collaborative process. One of the outcomes of this process will be state and regional committees charged with finding ways to connect services at multiple levels, including issues of funding, licensure/credentialing, and information sharing. Several subsequent activities will help develop and stabilize the infrastructure to sustain integrated services.

System Level Outcomes

- 1) Identification of objectives to involve important stakeholder communities (e.g., Native American, families, etc.) in the planning processes.
- 2) Establishment of regional focus groups with DMH and DADA representatives, administrators from each CMHC and CSA, Native American leaders/elders and service providers, the National Alliance for the Mentally Ill (NAMI), the Indian Health Service (IHS), the DOC, social services agencies, education professionals, primary care physicians,

consumers and family members and any other groups or agencies who desire to participate. These focus groups will serve as a platform to discuss integration of MH/SA services and build consensus on the mission and objectives of the action plan. This will enable future goals and activities to be coordinated via linkages to agencies across the state and allow for regionally-significant adaptations to occur.

- 3) Development of consensus regarding South Dakota's plan to integrate services and improve treatment for individuals with co-occurring disorders including:
 - Screening all individuals for the presence of co-occurring disorders;
 - Assess the severity of co-occurring disorders;
 - Treat co-occurring disorders in a comprehensive and coordinated manner; and
 - Train all mental health and substance abuse providers in the screening and assessment of co-occurring disorders.
- 4) Implementation of focused policy roundtables to bring together professionals from substance abuse and mental health to discuss common policy objectives as they relate to licensure/credentialing, funding, training/continuing education, and information sharing.
- 5) Identification of systemic barriers via review and synthesis of information gathered from search committees and focus groups.
- 6) Creation of a strategic plan that delineates 6, 12, 24, 48, and 72 month goals and objectives at the system, program, clinical practice and clinician levels.

Strategy 3: Develop a plan for the integrated screening process, research available screening and assessment instruments, and present findings to stakeholder groups and gather consensus around instruments to be used. Strategy 3 directly addresses the SAMHSA capacity-building goal of screening and assessing all individuals for co-occurring disorders. The Program Manager and the Steering Committee will develop general policies and guidelines for implementation in the seven CMHCs/CSAs and the HSC. This includes coordinating an educational and consensus campaign to solidify buy-in from the administrative/management level at the CMHCs/CSAs and the HSC. Administrators can then communicate the goals of integrated screening and encourage feedback about feasibility of such implementation.

It will be important to chronicle the barriers (e.g., credentialing, financial) to the provision of integrated screening and assessment. The plan for integration will include an examination of the scopes of practice for behavioral health providers to perform the screening function. The plan will also have to address reimbursement for the provision of screening and assessment functions.

A number of screening and assessment instruments exist that can be used to identify and assess the needs for persons with co-occurring disorders. At present, there is no standard for using these instruments or for ensuring that screening and assessment is implemented in existing programs.

Screening Instruments

A review of relevant literature regarding reliable and valid screening measures for co-occurring disorders will be conducted and then presented at the statewide conference. Attendees will be provided with relevant synopses of available instruments, followed by discussion of which measure to adopt. There are a range of such instruments available, such as the Alcohol Use Disorders Identification Test (AUDIT; Bohn, Babor, & Kranzler, 1995), MAST (Selzer, 1971), CAGE (Mayfield, McLeod, & Hall, 1974), DAST (Skinner, 1982), The Dartmouth Assessment of Lifestyle Instrument (DALI; Rosenberg et al., 1998), and The Alcohol Use Scale and the Drug Use Scale (Drake, Mueser, & McHugo, 1996).

As indicated, a primary outcome is a reliable and valid screening instrument that will be used uniformly across agencies/facilities in the state. A premium is on instruments with psychometric soundness *and* ease of administration. Also, in a choice of imperfect measures, one that errs on the side of false-positives is considered better than one that fails to identify those needing help. The target is high inter-rater reliability ($\geq 90\%$) as determined by performance measures during training sessions. Trainees will take written tests and rate videos, case vignettes, or role-playing exercises regarding a presented history of symptoms and behaviors. Measurement of performance will be conducted by independent evaluators (i.e., WICHE Mental Health Program).

Assessment Instruments

As with the screening instrument, a literature review regarding empirically-based assessment protocols will be conducted. While screening can identify the potential of a co-occurring disorder, assessment is a thorough evaluation that identifies the actual presence of such disorders to ensure appropriate treatment. Carey (2002) notes the importance of taking a holistic perspective in assessing co-occurring disorders: “evaluat[e] the social and motivational context of assessment, considering the impact of mental status and acute symptomatology, limitations associated with acute and chronic cognitive impairment, and evaluating the relevance of assessment items to the psychosocial context of persons with comorbid disorders” (p. 1346).

Regarding assessment protocols, Carey (2002) indicates that a number of different aspects of substance abuse can be assessed, including consumption patterns, psychosocial problems related to substance abuse, situations associated with abuse, motivation for change, and treatment involvement. There are instruments for each of these areas, but not all have undergone enough research to be considered psychometrically sound. However, South Dakota will identify or develop a reliable, valid instrument used uniformly across facilities, with a target of high inter-rater reliability and referral to appropriate treatment. Again, measurement will involve performance on written tests and rate videos, case vignettes, or other pseudo-clinical situations.

System Level Outcomes:

- 1) Identification of appropriate culturally sensitive screening instruments.
- 2) Assessment approach for MH/SA is developed.
- 3) Presentation of findings to a state-wide group of stakeholders (especially administrators and staff at the CMHCs/CSAs and the HSC) to review all screening and assessment instruments for appropriateness to South Dakotan populations and cultures.

Program Level Outcomes

- 1) Staff of both SA and MH agencies will screen all individuals coming in for treatment.
- 2) All persons who screen positive for both SA and MH receive full assessments.

Strategy 4: Develop a quality improvement strategy to monitor the outcomes of the screening process for individuals with co-occurring disorders.

A quality improvement strategy is imperative to this effort. Robust data from initial implementation of this project through each strategy will provide information on which to judge the progress of the co-occurring integration project. A quality improvement strategy will define the criteria and targets, monitor progress, and increase the percentage of clients who receive appropriate treatment following screening and assessment.

Training and clinical work at the CMHCs/CSAs and the HSC will provide concrete experiences and data that inform the organizational focus and action plans. Evaluations at

different points in the process will afford ongoing assessments of the viability of infrastructure changes, as well as potential directions for needed changes. Additionally, utilizing a multi-phase approach to the dissemination of training will enable application of the lessons learned at CMHCs/CSAs and the HSC to expansion into other provider sites in the state. Thus, South Dakota's vision of integrated services for individuals with co-occurring disorders will be founded on ideas guided by data.

System Level Outcomes:

- 1) Data on clients with co-occurring disorders and services are entered into the STARS system
- 2) Data collected on reliability and accuracy of screening and assessment results.
- 3) Information-sharing system established to communicate progress and barriers to complete implementation of screening and assessment training.
- 4) Routine quality improvement activities include monitoring whether providers are doing screening and assessment for co-occurring disorders, and appropriately entering findings into the state-wide communications system.

Program Level Outcomes

- 1) An audit procedure is identified and implemented for determining adherence to administering these measures and reporting the findings at six-month reviews.
- 2) Data on clients with co-occurring disorders and services are entered routinely into an integrated MIS.
- 3) Provide an evaluation mechanism to insure cultural inclusivity of Native American populations and the use of culturally appropriate assessment tools.

As a part of this strategy, barriers to implementation will be reviewed:

- *Examine the Current Treatment Funding and Reimbursement Structure.* Current reimbursement practices inhibit coordination/integration of services and effective treatment for persons with co-occurring disorders. Mental health and substance abuse services are funded through separate Federal, State, tribal, tribal-organizational, and private funding sources. The goal of comprehensive financial planning is the development of effective and innovative approaches for coordinating funds from these multiple programs to fund seamless services for individuals with co-occurring disorders—while maintaining accountability—and the removal of barriers that inhibit effective resource coordination.
- *Licensing and Certification:* Licensing requirements for mental health and substance abuse providers have historically been governed by separate credentialing bodies. In order facilitate treatment for individuals with co-occurring disorders, there needs to be consensus on the scopes of practice and competencies for these two groups. It is also important to begin a dialogue about addressing the lack of providers in rural areas and for Native populations. Modified licensing requirements may be necessary in order to meet the workforce needs in more remote areas.

Strategy 5: Develop and implement an initial system-wide training plan for the seven CMHCs/CSA providers and the Human Services Center (HSC), followed by a role out to the remaining 4 CMHCs and 6 CSAs. Follow-up measures will be conducted to determine the extent of training success and to identify areas in need of further training. In order to ensure referral to appropriate treatment pathways and positive outcomes, providers in multiple

settings need appropriate training in uniform, valid, and reliable screening and assessment procedures. Information sharing will be critical to this strategy. The training curriculum, developed by the Co-Occurring Steering Committee and other stakeholders will be disseminated to the target agencies. Trainers and consultants will be employed to provide this training and to provide technical assistance and support throughout the training process.

South Dakota's training will unfold over several stages and be informed by evaluation. The target during this grant period will be to train staff at the 7 CMHC/CSAs and the HSC. South Dakota will also monitor the implementation and outcomes of the integrated screening and assessment process on treatment pathways and client improvement (i.e., symptom reduction). Staff at subsequent sites and regional facilities involved in implementing integrated services will be future targets. Although the training plan has not been developed, we anticipate approximately 5 trainings in each implementation site: 1 systems change training, 1 cultural competency training, and 3 screening and assessment trainings.

The training plan will include strategies to address: a) site-specific training needs; b) inter-site training needs and general dissemination strategies; and c) training on special issues related to South Dakota's implementation (e.g., inter-site communications, rural implementation, serving the Native American population).

- **Site-Specific Training:** Site visits to the seven CMHCs/CSA sites will be conducted in accordance with the co-occurring disorders toolkit and fidelity measures. Evaluators will utilize the IDDT Fidelity Scale and General Organizational Index (GOI) to assess each site's current level of fidelity and identify areas in which improvement is warranted. Based on these assessments, evaluators will work closely with management staff at each location to develop a site-specific training protocol.
- **Inter-Site Training:** Shortly after completion of site-specific needs assessments, evaluators will complete a core training list. During this process, staff at each site and local stakeholders (e.g., consumers, family members, NAMI, IHS) will be identified to participate as members of a steering and oversight committee for the training and continuing education program which will be guided by the Co-Occurring Steering Committee. Funding will be available to support stakeholder participation.
- **Special Issues:** South Dakota will be consistently evaluating the progress of each site's efforts to provide reliable and effective screening and assessment. However, there is little doubt that unique issues will arise given the rural nature of the state. We see this as an excellent opportunity to address training needs specific to rural areas. Anticipated themes will include inter-site coordination, workforce issues, cultural competence, and sustainability.

System Level Outcomes

- 1) The creation of a training plan for providers in CMHCs/CSAs on the competent screening and assessment of individuals with co-occurring disorders.
- 2) Conferences and electronic media developed to maximize training efforts and facilitate information dissemination beyond the initial training sites.
- 3) Identification of trainers and consultants to disseminate training to target sites.
- 4) Progress will be tracked through the information-sharing system (STARS), and training effectiveness will be evaluated using performance measures completed at the end of training.

Program Level Outcomes

- 1) Each program has identified key staff to oversee site specific change process to implement universal screening and assessment.

- 2) All co-occurring providers (including key staff) are trained on an on-going basis in core competencies in screening and assessment.
- 3) High inter-rater reliability and high performance on provider tests of screening and assessment.
- 4) Training is delivered in a culturally sensitive manner with specific emphasis on training and treating people of Native American descent.
- 5) Policies and procedures are in place for obtaining a formal integrated assessment triggered by findings on the screening.
- 6) For implementing sites, key personnel will participate in monthly teleconferences focused on barriers to implementation and brainstorming sessions for innovative practice.

Affected Quadrants: Quadrants II, III, and IV will initially be the most affected by South Dakota's plan and activities. The capacity building goals will be implemented initially in the seven CMHCs/CSAs and the HSC, followed by the remaining CMHCs and CSAs. Consumers in these settings fall in Quadrants II, III, and IV. In the final years of the grant period, if possible, expansion will focus on other state agencies and community settings (e.g., schools, primary care). In essence, South Dakota seeks to ensure referral to appropriate service pathways via the screening and assessment procedures, with the long-term, post-grant goal of creating integrated, comprehensive treatment programs for individuals in Quadrants II and III.

A.4 SYSTEMS COORDINATION & FEASIBILITY

South Dakota has a history of working toward systems coordination and integration that will contribute to the success of the program. The DMH, DADA, and HSC are committed partners on this project and have already made some initial progress on discussing and planning for a treatment system that is prepared to provide integrated training and provide better treatment for individuals with co-occurring disorders. South Dakota attended the SAMHSA Co-Occurring Policy Academy and has since created a Steering Committee, held a large stakeholder planning meeting, and is working with Kenneth Minkoff, MD and Christie Cline, MD on an ongoing basis to advance this project. In addition, South Dakota's Governor is also in support of this initiative.

Infrastructure enhancement requires collaboration among multiple stakeholders, especially those in administrative and clinical positions. Services are more efficient and effective when agencies that were formerly separated work together under the same procedures toward the same goals. Below is a list of collaborative projects, programs, or initiatives in this regard, as well as brief descriptions of each:

List of Collaborative Activities in South Dakota	
1.	Children's Mental Health Task Force: The Legislature of South Dakota passed legislation in 2002 establishing a Children's Mental Health Task Force that included family members, the State House of Representatives, the State Senate, advocacy organizations, CMHC/CSAS providers, non-CMHC/CSAS providers, DHS, four other State Departments, and the Unified Judicial System. The purpose of the Task Force was to evaluate the current mental health care system for children in South Dakota and provide recommendations for system improvements to the Seventy-eighth Legislature.
2.	Serenity Hills: The only facility created jointly by the DADA and DMH with blended funding. It provides detoxification and halfway house programs for individuals who are chemically dependent or who have co-occurring disorders.
3.	Intensive Family Services (IFS) Program: A collaboration of DMH, DADA, DOC,

	and the Department of Social Services to provide mental health and alcohol-drug services to youth placed outside their homes and their families.
4.	DMH worked to help create a MOU with the Unified Judicial System and the Council of Mental Health Centers (which represents all CMHCs with whom DMH contracts) regarding the referral and delivery of home-based mental health services to youth involved with the court system. An MOU has also been created with DSS-Child Protective Services and the Council of Mental Health Centers regarding the establishment of a uniform intake/referral process and the adoption of principles for the co-management of referents. A similar MOU is also being created with the Department of Corrections and the Council of Mental Health Centers.
5.	DMH is involved in the State Placement and CHINS committees , which include several agencies (DDD, DOC, DSS, DOE, HSC) working collaboratively to recommend appropriate out-of-home placements, when necessary, for children and adolescents with a variety of emotional and/or social needs.
6.	The DMH has an agreement with the DDD regarding adult and child respite care services for families having a child or adult family member with a serious emotional disturbance or a severe and persistent mental illness.
7.	DADA has established a specialized program for substance abusing pregnant women and women with dependent children at two sites within the state. The program provides a full array of alcohol and drug and mental health services to this population within their treatment program.
8.	DADA has agreements with the Department of Social Services and the Bureau of Personnel to pre-authorize clients for chemical dependency treatment services and provide continued stay reviews for these clients while they are in treatment programming.
9.	Both the DADA and DMH operate a full array of assessment and treatment services within the adult and juvenile correctional facilities in the state. A memorandum of understanding details the scope of both operations.
10.	The Division of Mental Health is collaborating with Child Protective Services (CPS) to offer mental health services targeted to families with children who are at risk of being removed from their families. The purpose of these services is to intervene early with families who are involved with CPS and prevent out-of-home placement or reunify families when this has occurred. During FY04, the Division of Mental Health expanded this program to a second community mental health center. These programs have proven to be effective in keeping children in their homes and successfully reuniting children and families when this has occurred.
11.	The Division of Mental Health has been collaborating with the Office of Child Care Services to utilize funding in a manner that will allow mental health centers to consult with childcare providers to assist those providers in better serving children with emotional and behavioral issues. In FY04, the Division of Mental Health targeted additional funding to three mental health centers for services provided to children age five and under with SED. In FY05, the Office of Child Care Services has secured funding to support consultation services to childcare settings in four pilot sites which will assist childcare providers in effectively working with children in their care. The Division of Mental Health and the Office of Child Care Services will evaluate the effectiveness of this collaboration and combination of funding streams and will look to

	expand the services as needed.
12.	During FY02, the Division of Mental Health hosted a PATH TA training “Implementing Interventions for Individuals with Co-Occurring Mental Health and Substance Use Disorders.” This training was designed to assist providers in understanding co-occurring disorders and systems integration, particularly related to homeless individuals. During FY03, the Division of Mental Health hosted a second PATH TA training via teleconference. This training addressed collaborative relationships between mental health and substance abuse agencies. Training on co-occurring mental health and substance abuse disorders and the need for systems integration, formal cross-training/cross-staffing and effective treatment models were discussed. The training also focused on housing needs including the need to expand adequate housing opportunities and implement sufficient levels of supportive services to keep individuals housed.

South Dakota’s record of collaboration evidenced by the table above demonstrates our commitment to collaboration to improve cross-system coordination. We have chosen to focus very specifically on infrastructure development at the state and regional level and to implement training on screening and assessment with a manageable number of agencies (CMHC/CSAs, HSC) who already serve individuals with mental health and substance abuse problems. These agencies have a foundational knowledge of the need to treat co-occurring disorders in an integrated manner. Successful implementation in these agencies will provide a springboard to other expand training to other providers in the state.

SECTION B: ORGANIZATIONAL AND STAFFING PLANS

B.1 State-Wide Organizational Structure

The State of South Dakota has made a commitment to establishing a high-quality and efficient service system to serve all of its population’s mental health needs, including those with co-occurring disorders. Towards this end, the Governor’s Office has recognized the need for and begun the process of increasing the level of integrated service delivery and capacity building within the current system of care.

Overview

South Dakota’s Department of Human Services (DHS) is directly linked to the Governor’s Office and has under its purview the Division of Alcohol and Drug Abuse (DADA), the Division of Mental Health (DMH), and the Human Services Center (HSC). Historically, these three Divisions have worked independently. Two major additions to this existing structure will serve as the lead change mechanisms to the integration of these three Divisions: the *Co-Occurring Program Manager* and the *Co-Occurring Steering Committee*.

Co-Occurring Program Manager

South Dakota intends to create a position that will serve to link these three Divisions together, oversee the grant activities, and report to the Secretary of the DHS. This new “Co-Occurring Program Manager” will take on the main responsibility of the development of integrated, efficient and high quality services for individuals with co-occurring substance related and mental disorders.

There are several reasons for creating a separate Co-Occurring Program Manager position. First, in the spirit of integrating services, all Divisions must be on a level playing field. Choosing one Division to lead the effort could have the unwanted result of bias, favoritism or a sense of powerlessness for other Divisions. Second, although serving as coordinator and liaison among the Divisions, this person will be independent and, therefore, has the incentive to ensure collaboration among the groups. Third, this position will report to DHS and, thereby, the Governor, which will assure higher levels of involvement and oversight. Finally, collaborative efforts are often more efficient when there is a single entity acting to coordinate and consolidate efforts, rather than having multiple agencies potentially working on different schedules toward different goals or unnecessarily duplicating efforts.

Co-Occurring Steering Committee

To support the Program Manager's efforts and ensure consistent stakeholder input, South Dakota has taken the initiative to create the Co-Occurring Steering Committee. This committee was established at the South Dakota Stakeholder's Planning Meeting and was a direct result of South Dakota's involvement with the Policy Academy. It was designed to include members from the three primary Divisions as well as interested stakeholders from outside the Department. Some of the agencies or groups included are consumers and their family members, the National Alliance for the Mentally Ill (NAMI), the Indian Health Service (IHS), the DOC, social services agencies, education professionals, primary care physicians, and other groups or agencies. (Please see Appendix 1 for letters of support from various outside stakeholders). The Steering Committee meets quarterly and has already proven to be an excellent forum for on-going stakeholder input and guidance on this integration process.

Ongoing Communication and Joint Planning Activities

Together the Program Manager and the Steering Committee will be able to work together to achieve the primary goals of the integration plan *with stakeholder input at every level*. These joint planning activities will foster ongoing communication between the three Divisions and other stakeholders to achieve the goals of training, screening and assessment. The strong support of the Governor's Office will serve as a catalyst for continued communications among all partners at the state and local levels. All parties involved are committed to enhancing the current system and making the changes necessary to create an effective service system for individuals with co-occurring disorders.

B.2 Key Personnel—Qualifications and Roles

State of South Dakota Staff

The State of South Dakota staffing of key personnel is reflected in the following organizational chart as well as in the job descriptions contained in Section F.

Gib Sudbeck – (DADA Director)

Direct supervision over substance abuse services in CSAs and the DOC. Will also oversee relevant project operations within the DADA and collaborative with the Project and other Division Directors; help develop measures; data collection processes; staff coordination; oversee development of integrated services re: capacity building goals.

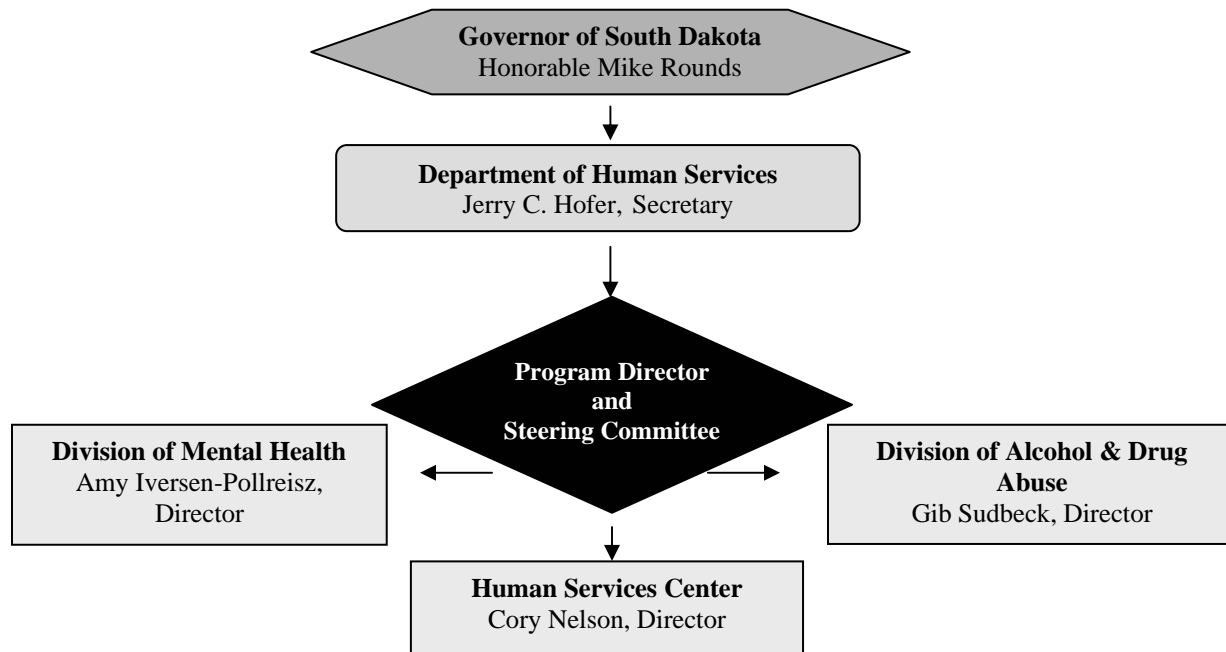
Amy Iversen-Pollreis – (DMH Director)

Direct supervision over mental health services in CMHCs and the DOC. Will also oversee relevant project operations within the DMH and collaborative with the Project and other Division Directors; help develop measures; data collection processes; staff coordination; oversee development of integrated services re: capacity building goals.

Cory Nelson – (HSC Director)

Oversees the services at the State Hospital, especially those run by the Director of Clinical Services. Will also oversee relevant project operations within the HSC and collaborative with the Project and other Division Directors; help develop measures; data collection processes; staff coordination; oversee development of integrated services re: capacity building goals.

Flowchart 1



Evaluation Staff (WICHE Mental Health Program)

Founded in 1955, the WICHE Mental Health Program is a collaborative venture with 15 western states. The program's mission is twofold: 1) to assist the states in the improvement of systems of care for persons with mental illness and their families; and 2) to advance the preparation of a qualified mental health workforce in the West.

Dennis Mohatt – (**Evaluation Coordinator**) is the Director of the Mental Health Program for the Western Interstate Commission for Higher Education (WICHE). Mr. Mohatt served as Deputy Director for the Nebraska Department of Health and Human Services from 1996-1999. He has over a decade of experience in community mental health, and provided executive leadership to a CMHC/CSAS in Michigan's rural Upper Peninsula, and the successful integration of community mental health services with primary care in two rural family medicine practices.

Mimi Bradley, Psy.D – (**Evaluation Staff**) is a Research Associate with the WICHE Mental Health Program. Her clinical experience includes individual, family, and group psychotherapy, and her specialties include rural mental health, behavioral health workforce development, forensic psychology, trauma, and multicultural issues. At WICHE, she is working on several regional initiatives to develop a larger and more effective mental health workforce in the Western states. She is a part of a research team for the HRSA-funded WICHE Rural Mental Health Research Center. Dr. Bradley has written and collaborated on several publications and presentations on rural mental health.

Outside Consultants

Kenneth Minkoff, MD – (**Consultant**) is a board certified addiction psychiatrist. Dr Minkoff is recognized as the premier consultant on developing comprehensive systems change because of

his equal familiarity and comfort with both administrative and clinical issues in addiction settings and in settings serving individuals with serious and persistent mental illness. He has conducted numerous teachings and trainings as well as program development, clinical treatment and system consultation in the area of co-occurring disorders since the mid-1980s.

Christie A. Cline, MD, MBA, PC – (**Consultant**) is a board certified psychiatrist and has a Masters in Business Administration with an emphasis in Strategic Planning. Dr. Cline has served as the Medical Director of the Behavioral Health Services Division of the New Mexico Department of Health and is largely responsible for the process of strategic planning and implementation of the New Mexico Co-Occurring Disorders Services Enhancement Initiative.

Mary Schumacher– (**Consultant**) Provide expert consultation regarding consensus building process, inter-site coordination, statewide expansion of capacity building goals, curriculum development.

B.3 Adequate Facilities and Equipment:

Facilities

The facilities to be used for implementation are adequate to serve the needs of this integration process. All facilities are compliant with the requirements of the American with Disabilities Act (ADA).

Equipment

The necessary equipment will include computer systems to communicate, enter data, and report results. All DHS agencies have the necessary computer hardware and internet access to complete these tasks. South Dakota has been developing an integrated data collection system for DMH and DADA (described more in a subsequent section). At present, the data, platform, and programming requirements of the system have been defined and the programming stage is underway.

B.4 Commitment to Comply

South Dakota is committed to comply with all aspects of SAMHSA's initiative, including:

1. Submitting quarterly progress and annual financial reports and a final report (with evaluation results and required co-occurring performance measures and a summary of the quarterly reports that describe the accomplishments of the project and planned next steps for continuing to implement service delivery improvements after the grant period).
2. Attending one technical assistance meeting during each year of the grant.
3. Participating in clinical, programmatic and evaluation activities with SAMHSA's technical assistance and support.
4. Cooperating and coordinating with SAMHSA's Co-Occurring Center for Excellence (COCE) to provide effective prevention and treatment services to meet the needs of persons with, or at-risk of developing, co-occurring disorders.
5. Informing the SAMHSA Project Officers of any publications based on the grant project, including publications occurring after the grant period ends.
6. Participating in an evaluation of the feasibility, validity, and reliability of the proposed co-occurring performance measures.
7. Conducting a local evaluation to monitor individual grantee progress towards achieving the goals and outcomes identified in the COSIG application that includes: implementation fidelity, process, and outcome.

8. Collaborating in the evaluation by attending one meeting annually, participating in the development of a cross-site evaluation plan, and submitting information consistent with the plan.

B.5 Post-Grant Sustainability

Although DHS is committed to moving towards co-occurring competency in all areas, existing dollars will make the immediate transformation of the system a longer term process. If the Department were awarded this grant, many system transformation components could be completed in a timely manner and then sustained in the long term with existing dollars. DHS has incorporated co-occurring competency within its annual strategic planning process for the past 4 years which demonstrates the commitment to implementing and sustaining co-occurring competent systems of care. Other ongoing efforts to provide a sustainable structure for the co-occurring project include:

- DHS has contracted with Ken Minkoff, MD and Christie Cline, MD to assist in the quality improvement efforts of the Department relative to co-occurring competency.
- DHS has initiated changes within the Department to support co-occurring treatment including adding substance abuse screening in the admissions office at the Human Services Center.
- The Division of Mental Health and the Division of Alcohol and Drug Abuse have jointly created a management information system that supports co-occurring treatment efforts.
- DHS has engaged key stakeholders in the planning process for system transformation towards co-occurring competency.

SECTION C: EVALUATION/METHODOLOGY

C.1. DATA COLLECTION

C.1.1 Current Capacity

South Dakota has several procedures through which data is collected. Until recently, the DADA and DMH collected and stored data separately. However, both the Division of Mental Health and the Division of Alcohol and Drug Abuse (DADA) received Federal Infrastructure Grant awards, which were used to create a Management Information System (MIS) that integrates DADA and DMH data.

The DMH and the DADA created a web-based MIS called STARS (State Treatment and Reporting System), which was implemented statewide in June 2005. STARS collects demographic, diagnosis and service utilization data for all individuals receiving publicly funded mental health and/or substance abuse services. Collection of this data now allows both Divisions increased capability for reporting to SAMHSA on the National Outcome Measures (NOMs). Along with this reporting, STARS now allows the Division of Mental Health and the Division of Alcohol and Drug Abuse to create reports containing data relative not only to individuals with co-occurring diagnoses, but also to individuals actually utilizing both mental health and alcohol/drug services. In addition, the new web-based system will allow for the development of a fee-for-service billing module that will allow providers to submit billing claims electronically in the ANSI X.12 format for HIPAA compliance. In return, the state will also be able to reimburse providers in the HIPAA correct format for claims submitted electronically, thus eliminating the current burden of paper transactions.

C.1.2 Plans for Data Collection/Reporting of Infrastructure and NOMS Measures

At present, South Dakota has some preliminary data on the percentage of clients (adults/youth) with symptoms of co-occurring disorders (see Section A.2). The current data includes individuals in substance abuse (SA) and mental health (MH) database files that have either 1) both a substance abuse and mental health diagnosis or 2) were served by both Divisions. Although some baseline data is available, the new STARS system will allow a more robust analysis of the numbers of people being served. STARS will support data collection at screening, admission, discharge and follow-up. STARS will be able to track the percentage of clients (adults and children/adolescents) in mental health and substance abuse programs with symptoms of the corresponding problem, through the co-occurring screening information entered for all individuals evaluated for services. STARS covers all of the mandated CSAT GPRA measures. All providers have been trained on entering appropriate data into STARS, with the few exceptions of individual agencies still modifying local systems to meet the uploading requirements.

With the increased data, both Divisions can better determine the service needs of individuals receiving these services. Reports can now be generated that will provide the needed additional information to develop policies/procedures relative to integrated treatment for individuals with co-occurring disorders. The STARS system was designed to be able to collect and report data in alignment with the Government and Performance Results Act (GPRA).

Infrastructure Measures

The STARS system will enable a more accurate analysis of the percentage of persons in either mental health or substance abuse programs with co-occurring symptoms. Initially, each of the seven CMHC/CSAs and the HSC will collect data from the point of service through discharge and follow up from treatment. As expansion across the state occurs, it is projected that by the end of the grant period, South Dakota will have more accurate estimates of the prevalence of co-occurring disorders. It is anticipated that integrated screening, assessment and training across CMHC/CSAs and the HSC will increase the identification of individuals with co-occurring disorder symptomology.

Regarding the percentage of treatment programs that screen, assess, and provide integrated treatment for individuals with co-occurring disorders, formal surveys of both mental health and substance abuse programs will be conducted throughout the grant period by the Division Directors (DADA, DMH, HSC) to determine the percentage of programs that screen, assess, and/or provide integrated services. A positive aspect of South Dakota in this regard is that it is a state-administered system with relatively few facilities, which enables the Division Directors to have close ties and good working relationships with administrators and clinicians at the sites under their respective purview. Thus, conducting a survey and collecting data regarding screening, assessment, and integrated treatment will be quite easy and fall within the timeline.

National Outcome Measures (NOMs)

As stated above, the STARS system currently allows some collection of the domains included in the NOMs (e.g., abstinence from substance abuse, decreased mental illness symptomology). In anticipation that these measures are likely to evolve, South Dakota's STARS system is flexible enough to include additional data elements as necessary.

C.1.3 Compliance with and Feasibility of Steps to Fulfill Reporting Requirements: The steps to ensure compliance with reporting requirements were detailed in earlier sections. The feasibility of implementing these steps is demonstrated by several aspects of South Dakota's current system and the process of achieving the capacity building goals. As noted, South Dakota

already collects data related to the measures and currently launched an integrated management information system (i.e., STARS), which will make analyses easier. There are solid relationships among Division Directors and their respective facilities. There have been previous joint initiatives between the DADA and DMH, as well as a number of treatment facilities that contain both substance abuse and mental health services. Thus, although significant infrastructure development is required to achieve the type of integration desired, steps have already been taken to move in that direction.

Regional consensus-building will create linkages among state and regional agencies, consumer groups, and other relevant stakeholders. This process necessarily involves identifying positive and negative aspects of the current system at both policy/regulatory and clinical levels. Identifying these aspects is necessary to defining achievable solutions. Furthermore, there will be an independent Program Manager overseeing the grant, as well as independent evaluators to help monitor progress. South Dakota is committed to cooperating with the SAMHSA cross-site evaluation to complete data reports, utilizing a web-based database developed in consultation with the Contractor.

C.2 LOCAL EVALUATION

C.2.1 Local Evaluation Plan

The local evaluation plan will be used to track progress toward meeting grant goals. The evaluation will be conducted by the WICHE Mental Health Program in conjunction with expert consultants (i.e., Ken Minkoff, MD) and COCE technical assistance. A process-oriented evaluation of implementing screening and assessment will be implemented to identify barriers or system components that need to be changed, as well as fidelity to implementation. Assessing outcomes of implementation involves charting of the number of individuals identified as having co-occurring symptoms, in which Quadrants they fall, and referral pathways.

Consumer outcome data will provide an estimate of the effectiveness of the screening and assessment in regard to moving consumers along appropriate treatment pathways. Quarterly and annual reports, based on weekly tracking mechanisms, will enable close monitoring of progress. Furthermore, WICHE will help develop the system of recording daily and weekly activities, as well as help to generate the periodic reports.

The proposed stepwise procedure for implementing screening and assessment will allow South Dakota to compare data in the areas indicated above to similar data for consumers who do not receive those services. That is, although the primary purpose of initial implementation in the CMHC/CSAs and HSC is to establish a sound organizational infrastructure and deliver high quality services, this work will also serve the secondary purpose of comparing processes and outcomes between CMHC/CSAs and HSC and other facilities. Expansion of screening and assessment services statewide will be greatly informed and made more durable through the initial roll-out to CMHC/CSAs and HSC. Potential barriers will be more easily anticipated and a knowledge base of achievable solutions identified.

C.2.2 Plans for Using Evaluation Findings

The primary purpose of collecting evaluation data is to monitor progress toward stated goals, identify barriers and deviations to this process, and to modify grant activities to increase fidelity toward these goals. It is important to be realistic and prepared for unanticipated barriers (e.g., staff changes, licensing, etc.) and to correct the course of action as we proceed. Evaluation data provides the mechanism to make appropriate modifications throughout the grant process.

Providers and staff at participating sites will collect data, but consumers and family members will be asked to complete anonymous satisfaction/outcomes surveys. Surveys and screening protocols will be used to gather information. Data collection for providers and training staff will be gathered during on-site evaluations or via the web-based technology described in the earlier. Consumer satisfaction surveys will be distributed through participating sites. An Evaluation Team will be created that includes key stakeholders, Steering Committee members, Native Americans, and consumers. The Evaluation Team will develop quarterly reports summarizing available evaluation data and make recommendations for revising implementation plans. These reports will serve as an ongoing documentation of project implementation over the grant period. The evaluation team will work to protect the privacy and confidentiality of consumer and family member responses. To minimize the risk of loss of confidentiality regarding assessment, satisfaction surveys and other data collection procedures will be anonymous.

C.2.3 Tracking Progress toward Implementation of Goals

Tracking progress toward implementation of stated goals include addressing both *process* (e.g., how closely did implementation match the plan) and *outcome* (e.g., what was the effect of infrastructure development on service capacity) components. We described plans (see Section A.3) to meet the following goals:

- 1) Establishment of a well-informed and coordinated state-level infrastructure;
- 2) Development of a clear and concrete action plan with regional and local input;
- 3) Development of a plan for the integrated screening process and identification of screening instruments and protocols;
- 4) Development of a quality improvement process to monitor outcomes of the screening process; and
- 5) Development and implementation of a system-wide training curriculum and plan for the CMHC/CSAs and HSC.

Some of these goals are system-level goals that set the foundation to address the other three capacity building goals. A realistic timeline will be imposed on the above goals. The Evaluation Team will be responsible for determining if progress toward these goals via the timeline. A combination of performance indicators, key informant interviews, site visits, and surveys will be used to assess progress toward goals.

C.2.4 Assessing Implementation Fidelity

The Evaluation Team will be responsible for tracking fidelity to the implementation plan. For each of the strategies listed above, specific milestones or outcomes will be noted with attached timelines. The Evaluation Team will work with consultants from Ziallogic on the development of the Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services for individuals with co-occurring psychiatric and substance disorders which is designed to improve treatment capacity for these individuals in systems of any size and complexity. Minkoff and Cline (2002), consultants from Ziallogic, have also developed an instrument (COMPASSTM) to assess the fidelity of programs to a dual diagnosis model. Minkoff and Cline also developed instruments to assess the fidelity of a system to a dual diagnosis capable model (COFITTM), and to assess individual clinician's readiness to practice in a dual diagnosis program using the CODECATTM. These instruments are being used nationwide to evaluate similar projects and offer measures to evaluate system, program, and practitioner level progress. We will conduct interviews to assess progress in network building and system infrastructure. We

anticipate interviewing approximately 8-10 people at the State level and at least 2 people from each of the seven CMHC/CSAs and the HSC. Questions will include items that address infrastructure development, such as development of strategic plans and ways to track measurable progress. Information from these interviews will provide valuable data on the system change goals of moving toward dual diagnosis capability in South Dakota.

Progress at the program level will be assessed by conducting site visits and interviews at each of the CMHC/CSA sites and the HSC (State Hospital). Questions will address their progress toward the development of dual diagnosis capability in their program such as training on dual diagnosis model, access to screening and assessment tools, etc.

Progress at the practitioner level will be focused on those individuals who participate in and complete the training on integrated screening and assessment tools. Data from this group of individuals will allow us to better understand whether the training was effective and if it has an effect on the practitioner's ability to work with dual diagnosis clients.

Evaluation Topics

1. Systems level implementation of plan
 - Hire Co-Occurring Project Manager
 - Establish monthly Co-Occurring Steering Committee meetings
 - Establish and Extend Communications System
 - Establish Communication with External Consulting Team
 - Address Diversity, Cultural Competence, and Consumer Involvement
 - Conduct a State-Wide Stakeholder Conference
 - Establish Regional Groups through the CMHC/CSAs and the HSC
2. Develop a plan for the integrated screening process
3. Research screening and assessment instruments
4. Gather consensus on screening and assessment instruments
5. Develop a quality improvement strategy to monitor the outcomes of the training and screening process
6. Develop and implement a training plan for CMHC/CSAs and the HSC (State Hospital)
7. How many MH/SA practitioners receive training?
8. How effective is the training?
9. How many clients entered into the STARS system on a monthly basis?
10. Changes in the rates of occurrence of screening of co-occurring disorders?

Each evaluation topic will be measured with information from their corresponding data sources. The following table defines the targets, outcomes, and measures for tracking training, screening and assessment goals.

Goal	Targets	Outcomes	Measuring & Tracking
Training	1. Develop a curriculum that trains both MH and SA service providers in agreed-upon screening and assessment protocols. 2. Revise curriculum	1. Identify site-specific and inter-site training needs. 2. Train staff at CMHCs/CSAs and HSC sites. 3. Ongoing	1. High inter-rater reliability. 2. High performance on screening & assessment. 3. Use information-sharing system to

	as needed. 3. Uniform training for providers throughout the state.	training and continuing education for providers statewide.	communicate progress, barriers, etc.
Screening	1. Literature review of screening instruments. 2. Presentation of instruments at statewide conference. 3. Consensus around and choice of the instrument to be used.	1. Train providers then implement at CMHCs/CSAs and HSC sites. 2. Collect data on reliability and accuracy. 3. Revise training and then expand statewide.	1. High inter-rater reliability. 2. High performance on tests of screening. 3. Use information-sharing system to communicate progress, barriers, etc.
Assessment	1. Literature review of assessment protocols. 2. Presentation of findings at statewide conference. 3. Consensus around and choice of the protocol to be used.	1. Train providers then implement at CMHCs/CSAs and HSC sites. 2. Collect data on reliability and accuracy. 3. Revise training and then expand statewide.	1. High inter-rater reliability. 2. High performance on tests of screening. 3. Use information-sharing system to communicate progress, barriers, etc.

STARS will be able to track the percentage of clients (adults and children/adolescents) in mental health and substance abuse programs with symptoms of the corresponding problem, through the co-occurring screening information entered for all individuals evaluated for services.

C.2.5 Inclusion of Target Population and/or Advocates in Evaluation Process

South Dakota will pay special attention to the cultural appropriateness of instruments chosen. Intrastate consultants (e.g., IHS) and focus groups of consumers, family members, and consumer advocates (e.g., NAMI), as well as national experts in cultural competence (e.g., WICHE) will play a vital role in this regard. These groups will be included in each phase of the grant work and stakeholders from these groups will be invited to participate on regional and state subcommittees. Similarly, consumers from the target population, regardless of background, will be asked for feedback throughout the process via targeted forums and activities. Staff at all levels of this project (i.e., Co-Occurring Project Manager, CMHC/CSA staff) will participate in cultural competence training that is specific to screening, assessment, and treatment of co-occurring disorders. The evaluation design will include a participatory evaluation orientation which integrates and coordinates stakeholder participation in evaluation activities at every level. Trainings and consumer input will help system developers and evaluators recognize quality assurance needs, and a results-oriented data management system at each level of the system will produce continuous feedback as to program effects.

SECTION D: LITERATURE CITATIONS

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**SECTION E: BUDGET JUSTIFICATIONS, EXISTING RESOURCES AND OTHER
SUPPORT**

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SECTION F: BIOGRAPHICAL SKETCHES AND JOB DESCRIPTIONS

BIOGRAPHICAL SKETCH

NAME Amy Iversen-Pollreisz	POSITION/TITLE Director, Division of Mental Health
ORGANIZATION	South Dakota Dept. of Human Services

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
South Dakota State University; Brookings, SD	MS	1997	Counseling & Human Resource Development
Dakota Wesleyan University; Mitchell, SD	BA	1994	Psychology; Human Services; Sociology

PROFESSIONAL EXPERIENCE

May 2005 – present	Director, Division of Mental Health; South Dakota Dept. of Human Services, Pierre, SD
August 2001 – May 2005	Community-Based Program Manager, Division of Mental Health; South Dakota Dept. of Human Services; Pierre, SD
July 2000 – August 2001	Child & Adolescent Program Specialist, Division of Mental Health; SD Dept. of Human Services; Pierre, SD
Jan. 1997 – May 2000	Elementary School Counselor; Stanley Co. School District; Ft. Pierre, SD

As director of the Division of Mental Health, Ms. Iversen-Pollreisz is responsible for community and correctional based services for people with mental illness, including a staff of thirty-five and a budget of \$25 million. She is involved in budgeting and legislative processes and a member of various workgroups to address mental health needs of South Dakota citizens, including the Governor's Mental Health Planning and Coordination Advisory Council.

RELATED PROFESSIONAL EXPERIENCE

2005- present	Appointed by the Governor to serve on the South Dakota Mental Health Advisory Council
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BIOGRAPHICAL SKETCH

NAME Gilbert Sudbeck	POSITION/TITLE Director, Division of Alcohol & Drug Abuse
ORGANIZATION	South Dakota Dept. of Human Services

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
University of South Dakota, Vermillion, SD	MA	1980	Counseling, Guidance, & Personnel Services
University of South Dakota, Vermillion, SD	BS	1978	Social Work; Psychology (double major)

PROFESSIONAL EXPERIENCE

1990-present	Director, Division of Alcohol & Drug Abuse, South Dakota Dept. of Human Services, Pierre, SD.
1988-1990	Director, Corrections Substance Abuse Programs, Dept. of Corrections, Pierre, SD.
1986-1988	Alcohol and Drug Supervisor & Counselor, Chemical Dependency Program, Lewis and Clark Mental Health Center, Yankton, SD.
1981-1986	Alcohol and Drug Supervisor & Counselor, Human Services Center, Yankton, SD.
1980-1981	Social Worker II, Youth Drug & Alcohol Treatment Program, Human Services Center, Yankton, SD.
1978-1979	Social Worker I, Center for the Developmentally Disabled, University of South Dakota, Vermillion, SD.

RELATED PROFESSIONAL EXPERIENCE

2004-present	Appointed by the Governor to serve on the Juvenile Justice Task Force for the State
2004-present	Project Director for the FASD Prevention Project through the Center for Excellence
2003-present	Named as the Fetal Alcohol Syndrome Coordinator for the State of South Dakota
2003-present	Regional VIII representative for the National Association of Alcohol and Drug Abuse Directors
1996-2001	Project Director, State of South Dakota Needs Assessment.
1988-1990	Member of the Advisory Committee for the South Dakota Human Services Center Adolescent & Adult Alcohol & Drug Treatment Program.
1986-1991	Case Presentation Methods Evaluator for South Dakota Chemical Dependency Certification Board, Inc.
1986-1990	Education & Training Specialist for Counselors Reciprocity Consortium/Alcohol and Other Drugs of Abuse (a 37-state chemical dependency consortium).
1988-1990	Vice-Chairman of the South Dakota Chemical Dependency Certification Board, Inc.
1987-1988	Representative for the South Dakota Chemical Dependency Counseling Field to President Reagan's Conference on a Drug-Free America.

PROFESSIONAL CERTIFICATION

1986-present	South Dakota State-Certified Level III Chemical Dependency Certification.
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BIOGRAPHICAL SKETCH

NAME Cory Nelson	POSITION/TITLE Administrator/CEO, South Dakota Human Services Center
ORGANIZATION	South Dakota Dept. of Human Services

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
University of South Dakota, Vermillion, SD	MPA	2005	Public Administration
Wayne State College, Wayne, NE	BS	1990	Criminal Justice, Corrections & Law Enforcement

PROFESSIONAL EXPERIENCE

2001-present	Administrator/CEO, South Dakota Human Services Center, South Dakota Dept. of Human Services, Yankton, SD.
1999-2001	Director, Division of Juvenile Corrections, Dept. of Corrections, Pierre, SD.
1997-1999	Juvenile Corrections Agent Supervisor, Division of Juvenile Corrections, Dept. of Corrections, Watertown, SD.
1996-1997	Juvenile Corrections Agent, Division of Juvenile Corrections, Dept. of Corrections, Watertown, SD.
1992-1996	Chief Court Services Officer, South Dakota Unified Judicial System, Pierre, SD.
1991-1992	Court Services Officer, South Dakota Unified Judicial System, Winner, SD.

RELATED PROFESSIONAL EXPERIENCE

2001-present	Appointed by the Governor to serve on the South Dakota Mental Health Advisory Council
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BIOGRAPHICAL OUTLINE FORM

NAME: <i>Dennis F. Mohatt</i>	TITLE: Program Director
ORGANIZATION:	<i>WICHE Mental Health Program</i>

INSTITUTION (Name, City, State)	DEGREE	YEAR	FIELD OF STUDY
Mansfield University, Mansfield, PA	M.A.	1984	Community-Clinical Psychology
University of Oregon, Eugene, OR	B.S.	1981	Psychology

PROFESSIONAL CREDENTIALS

Psychologist Limited License, Michigan; Certified Social Worker, Michigan

EMPLOYMENT

2001-pres Senior Program Director, Western Interstate Commission for Higher Education (WICHE) Mental Health Program, Boulder, CO.

2000-01 Vice President of Development, ABSolute Integrated Solutions, FHC Health System, Inc., Norfolk, VA.

1999-00 Western Regional Vice President for Program Development, Alternative Behavioral Services, FHC Health System, Inc., Norfolk, VA.

1996 Medicaid Managed Care Director, Dept of Social Services, State of Nebraska, Lincoln, NE.

1995-96 Executive Director, Child Guidance Center, Lincoln, NE.

1994-97 Senior Consultant, Frontier Mental Health Services Resource Network, Dept of Psychology, University of Denver, Denver, CO.

1994-98 Member, National Advisory Committee on Rural Health, U.S. Dept of Health and Human Services, Washington, D.C.

1989-95 Executive Director, Menominee County CMHC, Menominee, MI.

RESEARCH & PUBLICATIONS

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Mohatt, D. (2000). Access to Mental Health Services in Frontier America. *Washington Academy of Sciences* 86(3), 35-47.

Monroe-DeVita, & Mohatt, D. (2000). The role of the state hospital in the 21st century. *New Directions for Mental Health* (84), quarterly sourcebook. William Spaulding (Ed.). (San Francisco: Josey-Bass, Inc.).

Mohatt, D., & Monroe-DeVita, M. (1999). The illusive logic of behavioral health managed care "carve-outs". *Treatment Today*.

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- Mohatt, D. (1996). Rural issues in public sector managed behavioral health care. In Minkoff, K. & Pollack, D. (Eds.) *Managed Mental Healthcare in the Public Sector: A Survival Manual*. (New York: Harwood Academic).
- Ciarlo, J.A., Wackwitz, J.H., Wagenfeld, M.O., & Mohatt, D.F. (1996). Focusing on "Frontier": Isolated rural America. *Letter to the Field, No. 2*. (Denver, CO: University of Denver, Frontier Mental Health Services Resource Network).
- Mohatt D., & Kirwan, D. (1995). *Model Programs in Rural Mental Health*. (Washington, DC: U.S. Office of Rural Health Policy, DHHS, HRSA, USPHS).
- Wagenfeld, M., Murray, D., Mohatt, D., & DeBruyn, J. (1994). *Mental Health and Rural America: An Overview and Annotated Bibliography (Volume II)*. (Washington, DC: U.S. Government Printing Office).
- Mohatt, D. (1994). *Community Aspects of Health Care Reform and Rural Mental Health: Proceedings of the Conference: Implementing Health Care Reform in Rural America*. (Iowa City: University of Iowa Press).
- Larson, M.L., Beeson, P.G., & Mohatt, D. (1994). *Taking Rural Into Account: Report on the Center for Mental Health Services National Public Forum, Lincoln, Nebraska, June 24, 1993*. (Rockville, MD: U.S. Dept of Health & Human Services, Center for Mental Health Services).
- Mohatt, D.F., & Beeson, P.G. (1993). *Healthcare Reform and Rural Mental Health*. (Wood River, IL: National Association for Rural Mental Health).
- Mohatt, D., & Sharer-Mohatt, K. (1990). At risk rural youth: A community psychology approach to identification and intervention. *Proceedings of the Second Rural Mental Health and Addictions Conference*. (North Bay, Ontario: Addictions Research Foundation).

AFFILIATIONS

- 1982-pres The National Association for Rural Mental Health
1992-95, President
- 1982-pres American Orthopsychiatric Association, Fellow
- 1990-pres National Rural Health Association

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel in the order listed for Form Page 2.
Follow the sample format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME Mimi Bradley, Psy.D.	POSITION TITLE Research Associate		
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)</i>			
INSTITUTION AND LOCATION	DEGREE <i>(if applicable)</i>	YEAR(s)	FIELD OF STUDY
University of Illinois, Urbana-Champaign, IL	B.S.	1995	Psychology
California School of Professional Psychology, San Francisco, CA	M.S.	2001	Clinical Psychology
California School of Professional Psychology, San Francisco, CA	Psy.D.	2004	Clinical Psychology
University of Colorado Health Sciences Center, Denver, CO	Postdoctoral Fellow	10/01/04 – 9/30/05	Administration and Evaluation Psychology

A. Positions and Honors.

Current	Research Associate, Western Interstate Commission for Higher Education (WICHE) Mental Health Program
2004 – 2005	Postdoctoral Fellow, University of Colorado Health Sciences Center, at the Western Interstate Commission for Higher Education (WICHE) Mental Health Program
2003 – 2004	Pre-Doctoral Intern at the University of Colorado Health Sciences Center
2002 – 2003	Adjunct Faculty; National University, San Jose, CA
2001 – 2003	Clinical Practicum; Xanthos, Inc., Alameda, CA
2002 – 2002	Personal Development Instructor; Alvin Ailey Summer Camp, Berkeley, CA
2000 – 2001	Clinical Practicum; Federal Corrections Institute, Dublin, CA
1999 – 2000	Clinical Practicum; Bay Area Women Against Rape, Oakland, CA

RESEARCH, REPORTS, AND PUBLICATIONS

Adams, S.J., & **Bradley, M.M.** (2005). Building Partnerships in Rural Mental Health Workforce Development. Prepared by the WICHE Mental Health Program supported by an educational grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

Adams, S.J., & **Bradley, M.M.** (2005). Community Readiness for System of Care Change in the Mat-Su Region. Prepared by the WICHE Mental Health Program for the Alaska Division of Behavioral Health.

Adams, S.J., & **Bradley, M.M.** (2005). Integrated Services for Children and Families in the Matanuska-Susitna Borough, Search Conference, April 27-28, 2005, Wasilla, Alaska. Prepared by the WICHE Mental Health Program for the Alaska Division of Behavioral Health.

Mohatt, D.F., Adams, S.J., & **Bradley, M.M.** (2005). Rural Mental Health: Opportunities and Challenges Caring for the Country. In: *Universal healthcare: Readings for the mental health professional*. Cummings, N. & O'Donohue, W. (Eds.).

Mohatt, D.F., **Bradley, M.M.**, Adams, S.J., & Morris, C.D. (in preparation). Mental Health and Rural America: 1994 – 2004, An Overview and Annotated Bibliography. Rockville, Md. Office of Rural Health Policy, HRSA, and Office of Rural Mental Health Research, NIMH, NIH.

BIOGRAPHICAL SKETCH

NAME Jenny Shaw	POSITION/TITLE Project Manager
ORGANIZATION WICHE	Mental Health Program

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
Flathead Valley Community College, Kalispell, MT			General studies
University of the Nations	Certificate	1979	Leadership

EMPLOYMENT

WICHE (Western Interstate Commission for Higher Education). Boulder, CO
March 2002 to present Administrative Assistant

HOPE RANCH. Whitefish, MT
September 2001 to February 2002 Case Manager
March 2001 to September 2001 Resident Assistant

SELF-EMPLOYED

1997-March 2002 Web Page Design and Maintenance
Secretarial/Bookkeeping

BIOGRAPHICAL SKETCH

NAME Mary Schumacher	POSITION/TITLE Director
ORGANIZATION	Behavior Health Services (New Mexico)

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
Webster University St. Louis, Missouri	MA	1987	Counseling
University of Dayton Dayton, OH	BA	1970	Social Work

PROFESSIONAL EXPERIENCE

12/2002 – Present: University of New Mexico Health Sciences Center
 3/2003 – Present: Director of Albuquerque Metropolitan Central Intake (AMCI)
 1/99 – 12/2002: Director of the Behavioral Health Services (New Mexico Department of Health)

RELATED PROFESSIONAL EXPERIENCE

Mary Schumacher is currently the Director of the AMCI, which provides assessment of substance abuse disorders and evaluates vouchers for treatment. As Director of the Behavioral health Services in the New Mexico Department of Health, her responsibilities included direction, policy development, and implementation of mental health and substance abuse treatment and prevention services for New Mexico. She managed the federal and State block grant, discretionary funding and general fund for service delivery and implementation of system changes from centralized fee for services to regional management of continuums of care.

Prior to this, she was the Hospital Administrator for Turquoise Lodge and the Interim Hospital Administrator for the New Mexico Veterans Center. Mary has worked in various administrative positions in the New Mexico Department of Health since January, 1988.

Her other professional experience includes social work, community mental health series delivery systems and community-based placement of special populations, social services, paralegal activities related to health care, and medical malpractice litigation.

BIOGRAPHICAL SKETCH

NAME Kenneth Minkoff, M.D.	POSITION/TITLE Senior Systems Change Consultant
ORGANIZATION	ZIALOGIC

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
University of Pennsylvania School of Medicine	M.D.	1972	Medicine
Harvard University, Cambridge, MA	Pre-Med Studies	1969	Medicine
Harvard College, Cambridge, MA	A.B.	1968	

PROFESSIONAL EXPERIENCE

ZIALOGIC, ALBUQUERQUE, NM

Chief Consultant/Systems Change Expert, April 2001 - Present

Dr. Minkoff, developer of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model and its associated "Twelve Step Program of Implementation," is a nationally known systems change expert. He is currently a consultant to numerous statewide consensus-building initiatives designed to create integrated systems of care for dual diagnosis of SPMI and substance disorder. Dr. Minkoff was Chair of the SAMHSA Managed Care Initiative Panel on Co-occurring Disorders in the mid-nineties, and co-authored the co-occurring disorder issues paper for the President's New Freedom Commission in 2002.

CHOATE HEALTH MANAGEMENT

Medical Director, 1996-2003

Responsible for medical leadership of a wide range of contracted relationships to provide management and program development services for behavioral health entities in numerous states, including Massachusetts, Vermont, Maine, and Tennessee. These programs included inpatient, partial hospital, outpatient, and crisis stabilization programs, for both adults and children, and for both mental health and substance abuse services.

ARBOUR-FULLER HOSPITAL, ARBOUR HEALTH SYSTEM

Medical Director, 1998 - 1999

Responsible for the medical leadership of an 82-bed psychiatric hospital, with adult, dual diagnosis, developmental disability, and adolescent inpatient programs, plus partial hospitalization

CHOATE INTEGRATED BEHAVIORAL CARE

Medical Director, 1996 - 1997

Company-wide Medical Director of a national public/private psychiatric and addiction managed-care oriented provider system. Responsible for overall quality enhancement; standards; clinical policies and procedures; and the training, recruitment, and supervision of regional medical directors and programs.

CHOATE HEALTH SYSTEMS, INC.

Chief of Psychiatric Services, 1990 - 1995

Directed clinical services in a free-standing psychiatric hospital. Responsible for management and coordination of psychiatric and addiction inpatient unit, respite services, psychiatric day treatment, emergency services, addiction day treatment, and coordination with private and public providers.

CHOATE-SYMMES HEALTH SERVICES, INC.***Chief of Psychiatry, 1984 – 1990***

Responsible for the management and coordination of a psychiatric and addiction inpatient unit, emergency services, addiction day treatment, consultation and liaison, and outpatient services.

SOMERVILLE MENTAL HEALTH CLINIC***Clinic Director, 1978 – 1984***

Clinical and Administrative Director of a large community mental health clinic serving adults and children. Responsible for clinical leadership, program development, budgeting, grant writing, and staff supervision. Medical Director, Day Treatment Center, 1976-1978 Responsible for administration, coordination, clinical supervision, and case management in a full-time day treatment center program with 40 clients and 11 staff.

ACADEMIC APPOINTMENTS

From 1976 to the present, Dr. Minkoff has held academic appointments at Harvard Medical School in the Cambridge Hospital Department of Psychiatry. Since 1993, he has been Clinical Assistant Professor of Psychiatry.

SELECTED PRESENTATIONS & PUBLICATIONS

Since 1988, Dr. Minkoff has given more than 2,000 presentations in 45 States, Puerto Rico, Canada, France, Holland, and New Zealand.

Dr. Minkoff has served as a senior consultant on the development of the CCISC as a best practice model for enhancing services for individuals with psychiatric and substance disorders. His clients have included state and regional systems in Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, and Washington.

Dr. Minkoff has written more than 40 journal articles, book chapters, and monographs on a broad range of topics in the area of co-occurring disorders for the *American Journal of Psychiatry*, *American Journal on Addictions*, *Comprehensive Psychiatry*, *Disease Management & Health Outcomes*, *Hospital and Community Psychiatry*, *Innovations & Research*, *Journal of Alcohol and Drug Abuse*, *Journal of Psychoactive Drugs*, *Journal of Psychosomatic Research*, *Psychiatric Annals*, *Rehabilitation Psychiatry*, and *Western Journal of Medicine*, among others.

BIOGRAPHICAL SKETCH

NAME CHRISTIE A. CLINE, MD, MBA, PC	POSITION/TITLE Senior System Strategic Planner
ORGANIZATION	ZIALOGIC

EDUCATION

Institution & Location	Degree	Year Conferred	Field of Study
Medical College of Virginia, Virginia Commonwealth University	M.D.	1995	Medicine
Georgetown University, Graduate School of Business	M.B.A.	1989	Business
Southwest Texas State University, San Marcos, TX	M.S.	1984	Biology
Southwest Texas State University, San Marcos, TX	B.S.	1981	Biology

PROFESSIONAL EXPERIENCE

ZIALOGIC, ALBUQUERQUE, NM

President, April 2001- Present

President of ZiaLogic, a professional corporation that provides strategic planning and implementation consultation and support for behavioral health systems development, performs clinical and administrative trainings, provides technical assistance, and produces a variety of instruments and tools to support clinician development and system change. Dr. Cline partners with Kenneth Minkoff, M.D., a ZiaLogic Senior Systems Change Consultant, in the process of statewide co-occurring disorder program enhancement, curriculum development, and staff training. She has been instrumental in designing and implementing utilization of system change toolkit materials for development of the Comprehensive Continuous Integrated Systems of Care (CCISC) Model. Dr. Cline has joined Dr. Minkoff in collaborating on CCISC implementation projects in Vermont, Winnipeg; Grand Rapids, MI; San Diego; Lynchburg, VA; Washington, DC; Worcester County, MD; Tampa, FL; Manitoba; and British Columbia.

NEW MEXICO DEPARTMENT OF HEALTH

Director, Office of Behavioral Health Policy, Research, and Technology Transfer, Behavioral Health Services Division; November 2001 – May 2003

Responsible for planning, management, and coordination of all activities (both within BHSD and collaborative with other State agencies), regarding development and evaluation of behavioral health policy and strategic implementation of best practices.

NEW MEXICO DEPARTMENT OF HEALTH

Project Director, Co-occurring Disorders Services Enhancement Initiative; July 2000 – May 2003

Developed consensus on the need for prioritization of co-occurring disorders for best practice system development, created a strategic plan for structured implementation using quality improvement processes to incentivize change within the Regional Care Coordination system, and, with Dr. Minkoff, developed a toolkit and curriculum for implementation, and provided train-the-trainer initiative and program technical assistance statewide.

NEW MEXICO DEPARTMENT OF HEALTH

Medical Director, Behavioral Health Services Division (State Behavioral Health Authority), July 1999 – May 2003

Responsible for establishing medical oversight of quality improvement, standards of care, best practice development, and interagency collaboration throughout the entire behavioral health system of New Mexico.

NEW MEXICO DEPARTMENT OF HEALTH

Project Director, New Mexico Pharmacotherapy Initiative for the Treatment of Schizophrenia ; January 1999 – May 2003

Adapted TMAP to New Mexico, created implementation plan involving consumers, and developed structures for implementation statewide, involving ongoing support to physicians and nurses in all regions

SELECTED PRESENTATIONS

1. "Implementation of the Comprehensive Continuous Integrated Systems of Care Model in Multiple State Systems" Statewide System Integration Conference, Portland, OR, (May, 2003).
2. "Implementation of the Comprehensive Continuous Integrated Systems of Care Model for Individuals with Co-occurring Psychiatric and Substance Disorders, -- the New Mexico Co-occurring Disorders Services Enhancement Initiative," Presented at "Changing the World: Strategies for Systems Change to Implement Services for Individuals with Co-occurring Psychiatric and Substance Disorders" conference, Santa Fe, NM (April 2002)
3. "Implementation of the Comprehensive Continuous Integrated Systems of Care Model for Individuals with Co-occurring Psychiatric and Substance Disorders", Presented at the Annual Conference of the National Council of Community Behavioral Healthcare, Chicago, IL (March 2002)
4. "Co-occurring Psychiatric and Substance Use Disorders – Best Practice Treatment As We Know It.." New Mexico Treatment Providers, in Cooperation with the Center for Substance Abuse Treatment (February 2000)

Monographs and Publications:

Substance Abuse and Mental Health Services Administration—A strength- based systems approach creating integrated services for individuals with co-occurring psychiatric and substance use disorders—A technical assistance document. NMDOH/BHSD. April 2003 .

Center for Substance Abuse Treatment--Treatment Improvement Protocol For Co-occurring Psychiatric and Substance Use Disorders – Number 9 Revised (Consensus Panel Member) Pending Publication.
Minkoff, K and Cline, C. CODECAT™ (Version 1) Co-occurring Disorders Educational Competency Assessment Tool/Clinician Core Competencies for Co-occurring Psychiatric and Substance Disorders, ZiaLogic 2001.

Minkoff, K and Cline, C. COMPASS™ (Version 1) Comorbidity Program Audit and Self-Survey for Behavioral Health Services/Adult and Adolescent Program Audit Tool for Dual Diagnosis Capability, ZiaLogic 2001.

Program Manager Description

Title of Position: Co-Occurring Program Manager

Duties and Responsibilities: Final responsibility for South Dakota implementation; facilitating project kick-off and implementation plan; coalition building; communications with SAMHSA; policy-making for sustainability. They will also oversee relevant Project operations, evaluation and outcomes tasks within the State, serve as liaisons within the State, and oversee the completion of quarterly and annual reports. They will ensure the commitment of stakeholders in the Project including the involvement of the Advisory Councils and interested stakeholders.

Qualifications/Experience required for Position: Knowledge of applicable state and federal laws, rules, and regulations; human service programs; clients being served; program administration procedures; grant development and administration; technical knowledge of assigned programs. Ability to work effectively and efficiently with other staff and community organizations; identify dysfunctional relationships and environmental conditions; exercise sound judgment in the performance of assigned responsibilities; write meaningful, concise, and accurate reports and correspondence; analyze data and information and draw conclusions; train and advise program staff and service providers; assess program effectiveness.

Supervisory Relationships: May supervise subordinate staff.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in South Dakota, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of Travel – Special Conditions or Requirements: Periodic local and interstate travel. No special conditions or requirements.

Salary Range: Based upon qualifications. Program Manager will be paid with grant funding.

Hours per Day or Week: Full time

Job Description

Title of Position: Division of Alcohol and Drug Abuse (DADA) Director

Duties and Responsibilities: Direct supervision over substance abuse programs in CSAs and the Department of Corrections (DOC). Will also oversee relevant Project operations within the DADA and work collaboratively with the Project and other Division Directors; help develop measures; data collection processes; staff coordination; oversee development of integrated services re: capacity building goals.

Qualifications/Experience required for Position: Experience in substance abuse services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding persons with serious and persistent mental illnesses who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to Secretary of Human Services and Co-Occurring Program Manager. Supervises programs and personnel within the DADA.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in South Dakota, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: \$50,000-\$80,000/year based on full time status.

Hours per day or week: 10 hours per week

Job Description

Title of Position: Division of Mental Health (DMH) Director

Duties and Responsibilities: Direct supervision over mental health programs in CMHCs and the Department of Corrections (DOC). Will also oversee relevant Project operations within the DMH and work collaboratively with the Project and other Division Directors; help develop measures; data collection processes; staff coordination; oversee development of integrated services re: capacity building goals.

Qualifications/Experience required for Position: Experience in mental health services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding persons with serious and persistent mental illnesses who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to Secretary of Human Services and Co-Occurring Program Manager. Supervises programs and personnel within the DMH.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in South Dakota, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: \$50,000-\$80,000/year based on full time status.

Hours per day or week: 10 hours per week

Job Description

Title of Position: Humans Services Center (HSC) Director

Duties and Responsibilities: Oversees the services at the State Hospital, especially those run by the Director of Clinical Services. Will also oversee relevant Project operations within the HSC and work collaboratively with the Project and other Division Directors; help develop measures; data collection processes; staff coordination; oversee development of integrated services re: capacity building goals.

Qualifications/Experience required for Position: Experience in mental health services and programs, project management, and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding persons with serious and persistent mental illnesses who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to Secretary of Human Services and Co-Occurring Program Manager. Supervises programs and personnel within the HSC.

Skills and Knowledge Required: Knowledge of public mental health system policies, practices and services in South Dakota, understanding of interactions between the public mental health system and criminal justice system, understanding of program design, service and stakeholder linkage processes, understanding of data analysis and supervisory/project management skills.

Personal Qualities: Well-organized, able to communicate effectively with diverse stakeholders, ability to organize and present complex systems and data information for non-systems and data oriented audiences, and ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic local and, potentially, inter-state travel. No special conditions or requirements

Salary range: \$50,000-\$80,000/year based on full time status.

Hours per day or week: 10 hours per week

Job Description

Title of Position: Evaluation Coordinator

Duties and Responsibilities: Oversee day-to-day project activities; methodology development; budget oversight; supervision and coordination of data management, training and evaluation personnel; synthesis of ongoing and final report. Coordination of trainings and evaluation efforts. Involvement with program evaluation implementation and data analyses. Document processes undertaken to produce reports. Production of dissemination and annual progress reports, articles and presentations.

Qualifications/Experience required for Position: Experience in project management and program evaluation. Experience with the public mental health system and its interaction with multiple, state-wide systems. Experience with the issues surrounding persons with serious and persistent mental illnesses who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Reports to Co-Occurring Program Manager and supervises evaluators.

Skills and Knowledge required: Ability to track multiple tasks and activities. Excellent written and verbal communication with an ability to organize and present complex systems and data information to audiences that are not systems and data oriented. Knowledge of public agency systems. Ability to perform statistical analyses. Program evaluation skills and knowledge.

Personal Qualities: Well-organized, able to communicate and collaborate effectively with diverse stakeholders, ability to organize and present complex system structures to non-system and non-data oriented audiences. Ability to prioritize and multi-task.

Amount of travel and any other special conditions: Periodic inter-state travel and two-three out-of-state grant meetings. No special conditions or requirements

Salary range: \$90,000-\$100,000/year based on full time status.

Hours per day or week: 10 hours per week.

Job Description

Title of Position: Evaluation Staff

Duties and Responsibilities: Evaluation and data analysis; integrated report writing; coordination of training, conferences, and continuing education. Will monitor and evaluate programs, consumer outcomes, and initiate further evaluations (e.g., consumer satisfaction, family involvement). Will act as liaison between South Dakota and WICHE Mental Health staff.

Qualifications/Experience required for Position: Experience with program development and with clinical supervision. Knowledge of research methods, data analysis, integrated report writing. Knowledge of clinical issues related to persons with serious and persistent mental illness who are at risk for frequent hospitalization, acute crises, substance abuse, and involvement with the criminal justice system.

Supervisory Relationships: Supervised by Project Coordinator, supervises post-doctoral fellow.

Skills and Knowledge Required: Knowledge of co-occurring disorders and public mental health. Supervision and management skills.

Personal Qualities: Ability to work well with a diverse group of stakeholders and project staff. Ability to communicate effectively, problem solve and program development and implementation issues.

Amount of Travel – Special Conditions or Requirements: Some inter-state travel anticipated as part of this project. No special conditions or requirements.

Salary Range: \$50,000-\$55,000/year

Hours per Day or Week: 10 hours per week.

SECTION G: CONFIDENTIALITY AND PARTICIPANT PROTECTION REQUIREMENTS

1. Protect Clients and Staff from Potential Risks

Consumers with co-occurring disorders who seek services are, by definition, a vulnerable population. However, treatment is designed to minimize the risks consumers face. Any information requested of consumers (e.g., satisfaction surveys) will be anonymous and voluntary. Limited data collection should not exacerbate symptoms or lead to any other negative outcomes. Generally, the proposed activities are not expected to result in any physical or medical risks. However, it is possible that some risks are involved in the screening and assessment procedures. Specifically, these include:

- a) Becoming upset by evaluation questions regarding treatment;
- b) Disclosure of intent to harm others that could lead to legal intervention;
- c) Disclosure of child abuse that could lead to legal intervention;
- d) Loss of confidentiality.

Instances during the evaluation in which consumers become upset will need to be handled with clinical acumen. Clinicians will have to judge the intensity of the person's emotions and weigh it against the history of self/other violence, support network, access to weapons, and so forth. In some cases, acknowledging the person's distress and moving on to different topics will be sufficient. At the other extreme may be those who are acutely dangerous, in which case appropriate interventions will be made.

In this regard, intention to harm oneself or others, especially children or elderly persons, requires legal intervention. While this may be considered a risk to consumers in that confidentiality may need to be violated and/or they are involuntarily committed to a hospital, legal and ethical precedent in mental health requires that such actions be taken. One way to minimize these occurrences and associated risks is to maintain significant contact with high risk consumers and anticipate potential crises. Interventions and access to services that occur ahead of crises will help to reduce the incidence of acute dangerousness.

To minimize the risk of loss of confidentiality regarding assessment, satisfaction surveys and other data collection procedures will be anonymous. Other evaluation variables regarding services will be transferred and reported in aggregate to protect participants' confidentiality.

Finally, consumers seeking services will be asked to sign a consent form outlining all of the risks discussed above.

Consumers seeking treatment will be given emergency contact numbers as a standard component of receiving services. Clinicians at a given facility (or other crisis specialist staff) will be able to provide professional intervention in the event of adverse effects to consumers.

Consumers will generally be seeking outpatient or inpatient treatment, with screening and assessment being a component of that. However, groups such as NAMI offer a variety of

programs and support groups for consumers and their families, and this information will be passed on to consumers. Although cultural competence will be built into project activities, other resources, especially for Native Americans, that can augment treatment within a consumer's cultural context will be utilized. This may be through the Indian Health Services (IHS) or local support groups.

2. Fair Selection of Participants

The target population is youth and adults who are referred for treatment at either mental health or substance abuse facilities/programs. Specifically, the project seeks to identify either youth or adults with symptoms of both a mental health and substance abuse disorder.

South Dakota will serve those seeking services and does not discriminate against age, gender or race/ethnicity. Regarding women consumers who are or become pregnant, clinicians at participating facilities will follow protocols of assessing for access to appropriate healthcare services and make referrals as necessary. However, although pregnant women are a primary population served by the DADA, nothing about the project or its evaluation requires active recruitment of pregnant women.

This project is designed to meet the needs of individuals with co-occurring disorders in the most effective way. Many individuals with co-occurring disorders are at higher risk for numerous problems, such as health issues, legal difficulty, and homelessness. Clinicians at participating sites will follow appropriate protocols to reduce such risks.

Inclusion criteria are noted above and are consistent with the design and focus of the project. Consumers would be temporarily excluded from the project if their mental status was impaired to the point that they could not properly participate in screening or assessment procedures. However, these services would be given once stabilization occurred. Additionally, consumers who have already been diagnosed with a co-occurring disorder would not need to undergo further screening or assessment and, therefore, would not be included.

Participants will be those who seek services or are hospitalized. The screening and assessment procedures are considered a standard and appropriate means of providing the highest quality services and, therefore, are not an issue of recruitment or selection.

3. Absence of Coercion

Participation in treatment, for most consumers, is voluntary. However, court-ordered treatment is possible. Voluntary consumers are free to refuse or withdraw participation at any time. Refusal or withdrawn participation will not in any way affect linkage to treatment through either mental health or substance abuse facilities/programs, nor limit access to treatment in the future. This will be clarified with the consumer through the consent procedures. Also, any surveys and questionnaires are voluntary and anonymous.

Consumers in this project will not be paid.

Consumers who do not desire to participate in the screening or assessment procedures will be referred to services deemed appropriate based on other assessments.

4. Data Collection

Data will be collected primarily by providers and staff at participating sites, but consumers and family members will be asked to complete anonymous satisfaction/outcome surveys. Questionnaires, interviews, and screening and assessment protocols will be used to gather information. Data collection for providers and staff will be gathered during on-site evaluations or via the web-based technology described in the narrative section of this proposal. Consumer satisfaction surveys will be distributed by mail or through participating sites. The evaluation team will work to protect the privacy and confidentiality of consumer and family member responses.

No specimens will be collected as part of this project.

Copies of available data collection instruments and interview protocols are provided in Appendix 3.

5. Privacy and Confidentiality

Project site clinicians and evaluation staff will collect the majority of the evaluation data. However, consumers and family members may be involved in collecting consumer satisfaction and other outcome measures. All persons collecting data will be trained in the importance of maintaining confidentiality at all times. Access to project databases will be limited to project principals and the evaluation team. Data will be aggregated and coded to eliminate individually identifiable information. South Dakota agrees to agree to maintain the confidentiality of alcohol and drug abuse client records according to the provisions of Title 42 of the Code of Federal Regulations, Part II.

Data collection instruments will be used to assess 1) the presence of co-occurring disorders, 2) consumer outcomes, and 3) consumer satisfaction with services. Each of these pieces of data will be used to inform training and continuous quality improvement. The data will be stored in the Management Information System (MIS), which will be a secured database. The participating project sites, in accordance with State privacy and confidentiality statutes, will maintain individual case records.

6. Adequate Consent Procedures

Consumers will be informed of the nature and purpose of their participation in this project. Project staff will obtain informed consent related to any information collected that goes beyond standard services (e.g., satisfaction surveys). For evaluation components of the project, consumers will be informed that participation is voluntary and that even if they do agree to participate they can withdraw their consent at any time. Participants will be able to withdraw consent for the project evaluation without jeopardizing their therapeutic services in any way. They will be informed of the planned uses of the data collected and the procedures for keeping

data confidential. They will be informed of any risks of participation, and they will be encouraged to discuss any concerns or difficulties with project staff.

Participants and/or their guardians will sign a consent form outlining their understanding of this information. All participants will be given a copy of the consent form and will be encouraged to ask questions at any time.

Consent for youth under 18 years old will be received from parents or legal guardians, or via appropriate procedures as determined by statute. Assuming elderly persons enrolling in the program are competent to consent to services, regular procedures will be followed. The informed consent will be written at a reading level that is accessible to most consumers. However, if reading or language barriers exist, then the consent form will be either read and explained to them or translated. Consumers will be given copies of the consent, which will include emergency contact information, for their records. Presently, one consent form appears sufficient for the project period. If the evaluation protocol changes during the project and additional consumer input is desired, an additional consent will be obtained. As mentioned previously, individuals who decide not to participate in the project evaluation will still be able to receive appropriate services. A sample of the consent is found in Appendix 2.

7. Risk/Benefit Discussion:

The risks to participants of this project evaluation are minimal. The potential benefits to participants include the opportunity to advance scientific knowledge in the field, receive thorough assessment and appropriate diagnoses, and be referred to the most effective treatments based on their needs and symptoms.

APPENDIX 1
LETTERS OF COMMITMENT/SUPPORT

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APPENDIX 2

SAMPLE CONSENT FORM

South Dakota Co-Occurring Consent Form

Description

To provide the best services available, South Dakota is utilizing instruments that screen and assess for the presence of co-occurring disorders. A co-occurring disorder is when an individual has both a substance abuse and mental health disorder. Research indicates that individuals with co-occurring disorders need to have accurate diagnoses so that referral to appropriate treatment can be made. South Dakota is using screening and assessment instruments that have been found to be good at identifying co-occurring disorders. South Dakota will be collecting data regarding the screening and assessment procedures, the quality of services, outcomes, and your satisfaction with services. You will not be identified in any of the data, as measures are taken to ensure anonymity.

Procedures

All persons who receive treatment at this facility will be screened for the presence of a co-occurring disorder. Screening involves a brief series of questions, usually taking no more than 10-15 minutes. Based on the results of the screening, those who appear to have symptoms of a co-occurring disorder will be referred for a more thorough assessment. The results of that assessment will determine the referral to treatment.

As part of an effort to judge whether or not the screening, assessment, and referral procedures are effective, we will ask that you periodically complete brief surveys that ask about your experiences with treatment, including things that have been helpful or that have not. This information helps us to make adjustments in the program to better serve yourself and others. The surveys are a paper-and-pencil format and shouldn't take long to complete. The surveys are anonymous.

Discomforts and Risks

The screening and assessment has minimal risk to you and, in fact, seeks to guide you toward appropriate treatment to help your productivity and satisfaction with life. Sometimes treatment can be a difficult process, but its purpose is to help you improve your life in a manner you see fit. However, it is possible that unknown risks exist. Nevertheless, the program constantly seeks to identify and either remove or minimize risks that arise.

Benefits

There are no guaranteed benefits of the screening and assessment. Clinicians with whom you work try to address your individual needs. Surveys and evaluation tools you complete will help us continue to improve services.

Source of Funding

This program will be funded by a joint collaboration of the South Dakota Division of Alcohol and Substance Abuse (DADA), Division of Mental Health (DMH), and the Human Services Center (HSC) through a combination of grant funds, Title XIX and state general funds.

Cost to Subject

There is no cost to you for participating in the evaluation of the screening and assessment procedures.

Program Withdrawal

Taking part in these procedures is voluntary. You have the right to choose not to take part in the screening and assessment. If you choose to take part, you have the right to stop at any time. Program staff cannot decide to stop your participation without your permission.

Confidentiality

As a consumer of mental health and/or substance abuse services, you have a right to confidentiality of your records. However, circumstances that involve likely danger to yourself or others, or in which your health is being compromised, require that clinicians act to prevent harm to you or others. In these situations, clinicians may have to break confidentiality.

AUTHORIZATION:

I have read this paper about the program or it was read to me. I understand the possible risk and benefits of this program. I know that participation is voluntary. I choose to participate. I know I can stop participating in the program. I will get a copy of this consent form. (Initial all the previous pages on the consent form.

Signature: _____
Print Name _____ Date _____

Consent form explained by: _____
Print Name _____ Date _____

Investigator _____ Date _____

APPENDIX 3
DATA COLLECTION INSTRUMENTS/INTERVIEW PROTOCOLS

Michigan Alcohol Screening Tool

DSM criteria for Pathological Gambling code 312.31

Assurances page 1

SMA 170

Disclosure of Lobbying

Checklist